

MED - Nursing Facility Level of Care Certification Review

Purpose: All admissions of Medicaid members to a nursing facility (NF) require a level of care (LOC) certification form to be completed.

Prior to Medicaid payment being approved the Medicaid member must meet LOC guidelines completed by Medical Services and have preadmission screening and resident review (PASRR) completed by the current vendor. The LOC reviews are to be completed for members upon admission or new eligibility for Medicaid and any time there is a significant change in the member's status, either an improvement or decline in health, where the LOC may change. It is the NF's responsibility to notify Medical Services of any change in the member's condition.

Utilization Review staff may be reached by telephone, fax or email during regular business hours of 8:00 a.m. to 4:30 p.m. following the state holiday schedule. Voicemail boxes are secure and will be reviewed no less than twice daily. Utilization Review staff will respond to provider and member questions about the review process within one business day.

Identification of Roles:

Review Assistant (RA) – provides program support.

Review Coordinator (RC) – performs LOC assessments and provides education to members regarding care alternatives, provides appeal summaries as needed.

Manager – provides training and oversight in the field, tracks performance standards, produces reports, and conducts internal quality control for review decisions.

Medicaid Medical Director (MMD) – provides level of care determinations.

Clinical Assistant to the Medicaid Medical Director (CAMD) – reviews for level of care or quality of care concerns, makes medical necessity determinations, and approves corrective action plan requests that include quality of care concerns.

Performance Standards:

- Complete 95 percent of LOC determination for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of subsequent service review (SSR) within five business days of receipt of complete information. Complete 100 percent within ten business days.

Path of Business Procedure:

Step 1: The NF LOC certification form will be completed by a qualified medical professional and faxed to Medical Services at 515-725-1349.

- a. A qualified professional is a Medical Doctor (MD), Doctor of Osteopathy DO, Physician's Assistant or Advanced Registered Nurse Practitioner.
- b. A short stay NF admission will be identified on the LOC certification form as an individual being admitted to the NF directly from an acute hospital stay and having resided in their own home prior to the admission to the hospital.

Medicare clinical criteria and Iowa Administrative Code rules (IAC) are used for most medical necessity determinations. If Medicare and IAC rules criteria are not available or not appropriate, specific criteria may be developed by the review team of review coordinators (RC), manager, clinical assistant to the medical director (CAMD) using evidence-based guidelines, and must be approved by the physician medical director. The MMD and the Medicaid Clinical Advisory Committee (CAC) may also be involved in the development of clinical criteria. Criteria are reviewed and revised when changes are needed and no less frequently than annually.

Step 2: DHS Assessment and Services Evaluation (ASE) criteria are utilized by the RC to determine if the member meets the LOC based upon the information provided on the NF LOC certification form.

- a. The ASE criteria located at the end of this procedure beginning on page 18 are divided into ten areas:
 1. Cognitive, mood and behavior patterns
 2. Physical functioning and mobility
 3. Skin condition
 4. Pulmonary Status
 5. Continence
 6. Dressing and personal hygiene
 7. Eating
 8. Medications
 9. Communication, hearing and vision
 10. New criteria regarding NF short stay LOC reviews

Regarding criterion ten, in addition to application of the ASE criteria for NF LOC approval, RC will be checking for individuals who have lived in their own home or with family in a private home prior to discharge from acute hospital care. These members will receive authorizations for an NF stay of 30-60 days to assist in discharge planning back to home whenever possible. The intention is to increase the number of individuals who would be able to return to live safely in their own homes with waiver services and to decrease the length of stay (LOS) in NF.

Step 3: Any member must require assistance with dressing and bathing in order for the RC to approve the LOC or RC will utilize the MMD and approved NF decision tree.

- a. If assistance is not needed for these functions and if not approvable utilizing the NF decision tree, the case will require physician review (PR).

Step 4: Pediatric skilled criteria are utilized to determine skilled nursing needs for children age 17 and under.

Step 5: The RC will review submitted documentation to insure that the request is complete.

- a. When the RC cannot approve the member's LOC based upon the LOC certification form, the attending physician, or NF is contacted by telephone in an attempt to gather all available information regarding the member's functional status prior to taking the case to PR. Only information that is necessary to approve the service will be requested. For the potential short stay resident, the RC will check ISIS to determine if waiver services had been in place prior to the acute hospitalization. For short stay resident not previously on waivers, RC will refer hospital discharge planner or NF admission intake worker to advise the resident and their family of this option and encourage them to assist member and family in the application process for waiver if appropriate.

Step 6: The RA and/or RC will complete a request for additional information if needed. The RAs do not make clinical decisions or complete clinical interpretation of information.

Step 7: The RC will make no less than two attempts three working days apart by either telephone or email to contact the provider to obtain the required information regarding the member's status.

Step 8: The RA and/or RC will review submitted documentation to insure that the request is complete.

Step 9: The RC will obtain useful information prior to PR such as:

- a. complete medication lists
- b. current diagnoses list
- c. driving ability
- d. any other useful information

Only PRs make denial decisions. Denial decisions are made in writing by Notice of Action (NOA) and must include the principle reason and clinical rationale for the decision. Subsequent service review (SSR) denial NOA and Individualized Services Information System (ISIS) denials will be dated 15 days from the date of the physician review to allow for timely notice to the recipient. URAC standards of completion within 15 days will be followed.

Step 10: Denial is distributed by ISIS immediately upon PR denial.

Step 11: The NOA is completed and mailed out within one working day of the denial, the RC may call the NF to inform them of the denial as a courtesy but it is not required.

- a. The SSR denial NOA is dated 15 days from the date of the PR to allow for timely notice of the resident and to allow time for discharge plans, Admission denials are dated the same date at the PR.
- b. The PR includes licensed health care professions in the same category as the attending provider. Denials made by the CAMD will be reviewed by the MMD. Notice of the availability of the peer-to-peer conversation is included in the NOA. The manager will arrange for the peer-to-peer conversation within one business day of the request unless there are extenuating circumstances outside of Medical Services' control.
- c. If a denial decision made by the CAMD and referred to another PR besides the MMD is formally appealed, the manager will facilitate a second review by the

MMD prior to continuing with an appeal response only if new information is included with the appeal.

- d. Approval decisions are made in writing via ISIS and sent to the income maintenance worker (IMW). Members and/or attending physicians do not receive written notice of an approval; however, they will receive written notice upon request. Approval decisions may be reversed if additional information is received that contraindicates continued approval. Only information necessary to approve the service may be requested.

Step 13: RC will update the review information in Medicaid Quality Utilization Data System (MQUIDS) and request a LOC milestone in ISIS.

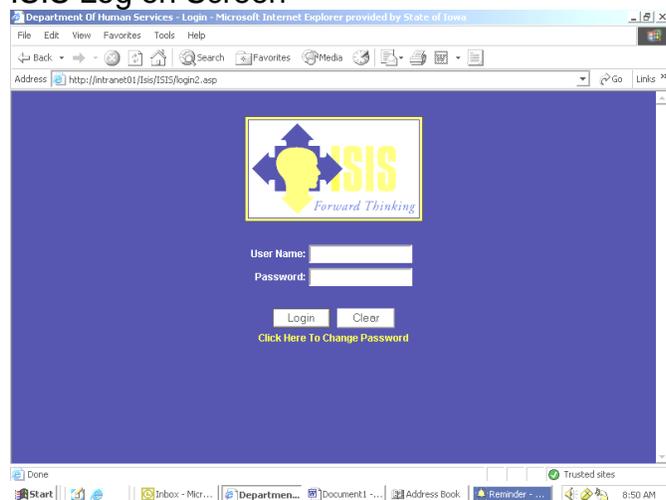
Step 14: Urgent requests will be reviewed and a decision rendered and communicated in no less than 72 hours from receipt of the request. A request is urgent if the situation poses an immediate threat to the health and safety of the Medicaid member or if the attending physician, member or family member indicates that the need is urgent. This time frame includes holidays and weekends.

Step 15: When an urgent request is received, the RC will confer with manager and log the request on the spreadsheet located at MedSrv/Urgent Requests/Urgent Request Tracking.

Step 16: When all available information is obtained the RC forwards the review information through OnBase.

Step 17: Following PR, the IMW is notified of the LOC review determination through ISIS.

ISIS Log on Screen



Step 18: Current workload is found by clicking on Consumer Tab and then My Workload.

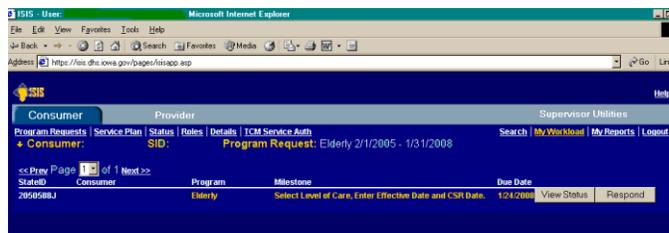
Step 19: The RC will review the ISIS workload page daily.

Step 20: The workload screen indicates what milestones are due for the RC to respond to for members.

Step 21: The RC will click on view status to review the activity for each member.

Step 22: The RC will have the ability to review previously completed activity by the DHS worker.

Step 23: The RC will click the respond button and data enter response.

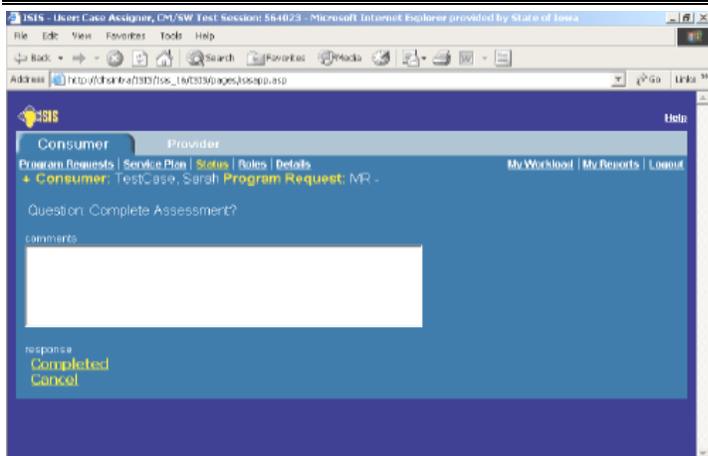


- To view status of a member, click on VIEW STATUS. This screen will show the steps that have already been completed and name of worker who completed each task. If no key tasks are waiting to be addressed, the screen will display No Workload Items Found.
- The STATUS screen shows contact information for people that have performed previous milestones and how to contact them.
- When a consumer case is added to the workload, it will be placed at the bottom of the list.
- Refresh the page from time to time. Refreshing will be done by going to another page and then returning by using the WORKLOAD tab.
- The PROGRAM REQUEST on the expanded consumer record is an abbreviated form of the program request record that is found by clicking on the PROGRAM REQUEST tab after selecting a consumer.
 - Denial notices of decision and appeal rights are provided to the member and NF by medical services.
 - Admission denials are effective from the date of admission.
 - Subsequent service denials go into effect 15 days following the PR date. The NOD date and ISIS will reflect this date.

Step 24: Fields on the Determine Assessment Status screen include:

- Comments section allows text entry of information that will be useful to others who will be involved in the case.
- Assessment completed.
- Assessment received but need more information is selected when additional information is required to complete assessment.

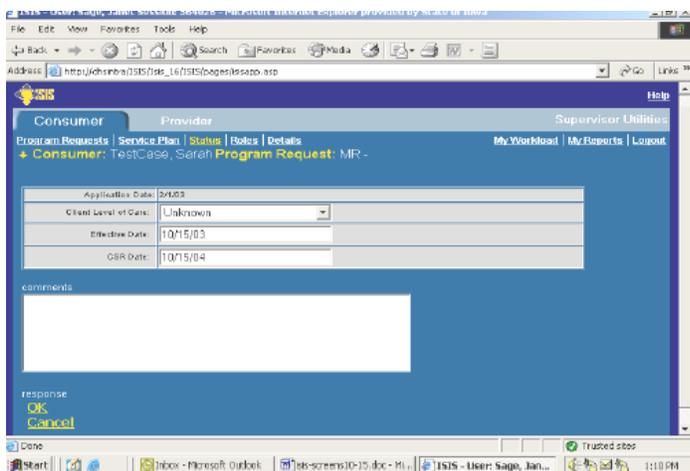
ISIS Consumer Assessment Status Screen



Step 25: From the WORKLOAD screen, the RC will select LOC key task milestone and click on respond button to access the LOC screen that follows.

Step 26: The RC will enter the level of care along with an effective date and a date for a subsequent service review. The fields for the LOC screen include:

- a. Client Level of Care: Select the correct level of care from the pull-down menu. Note that the choice of denied means the member does not meet any of the levels of care. If after an appeal, the denial is reversed the responses will need to be removed by using the undo feature on the STATUS page.
- b. Effective Date: Enter the date the level of care becomes effective.
- c. CSR Date: Enter the date chosen for the subsequent service review. If an entry is not made, the CSR Date will default to one year after the entered Effective Date.
- d. Comments: Allows text entry of information that will be useful to others who will be involved in processing this case.
- e. OK Response: Submits answers chosen above.
- f. Cancel Response: Postpones the response.



Step 27: Members meeting LOC for NF will be authorized for a period of one year unless otherwise specified by the PR.

Step 28: The RC will data entry results into MQUIDS by the second working day after the completion of the admission review and within five working days of completion of the annual assessment.

Step 29: The RC will document the clinical assessment information required to support LOC determination in the review screen that follows.

- a. Criteria are documented as well as the review type, admission date to the NF, dates LOC certification form was completed by the health care provider, date received by the RC, LOC decision and assigned days, and the date the review was completed by the RC.

Step 30: If the RC is not able to approve the LOC based upon the information received, the RC will document in comments the dates and information received by the NF or Attending Physician to support the LOC.

Step 31: If RC still not able to approve, all available information is taken to PR.

Forms/Reports:

NF Decision Desk Guide

Level of Care Certification Form submitted or SSR completed Information verified	Information obtained All information is consistent	Review Outcome
Member has Alzheimer diagnosis or related disorder, and bathing assistance of any type indicated. Scores 0-7 (severe impairment) on BIMS or other documentation indicates severe impairment.	Information is confirmed	Okay for RC to approve NF Level of Care. Meets criteria as has impaired decision-making and need for ADL supervision.
On NF admission or SSR, documentation indicates “independent”. No major change in condition and previously approved by PR or in ALJ appeal.	Information is confirmed	This will require Physician Review.
Member admitting to NF from EW, PD, HD, or BI Waiver, PACE, NF/MI, another NF, or if readmitted to NF from home within 30 days of a recent discharge.	If ISIS indicates a gap in service of more than 30 days, then a new Level of Care Certification Form is needed.	If gap 30 days or less in service, and PASRR is completed, and as long as NF Level of Care was previously approved, then okay for RC to approve NF Level of Care without a new Level of Care Certification Form.
Member admitting from NF to NF/MI Facility.		NF Level of Care Certification Form needs to be approved for NF/MI Level of Care based on NF/MI criteria.
Member admitting from NF/MI Facility to NF.		No new NF Level of Care Certification Form is needed, as long as previously approved for NF/MI Level of Care.
Member admitting to NF from ID Waiver (formally ICF/MR Waiver).		NF Level of Care Certification Form needs to be completed and approved for NF Level of Care.

Criteria

Nursing Facility Level of Care Criteria

Iowa Medicaid Program:	LTC Medical Criteria	Effective Date:	01/2012
Revision Number:	1	Last Review Date:	01/18/2013
Reviewed By:	Clinical Advisory Committee	Next Review Date:	01/2014
Approved By:	Medicaid Medical Director	Approved Date:	02/17/2012
Approved by:	DHS Policy Staff	Approved Date:	02/17/2012

Criteria:

Nursing facility level of care can be approved if the following conditions are met:

1. Presence of a physical or mental impairment which restricts the ability to perform the essential activities of daily living; bathing, dressing, and personal hygiene and impedes the capacity to live independently. The member's physical or mental impairment is such that self-execution of the required nursing care is improbable or impossible.
2. Services are provided in accordance with general provisions for all Medicaid providers and services as described within 441-79.9.

Change History:

Change Date:	Changed By:	Description of Change:	New Version Number:

Skilled Level of Care Criteria

Iowa Medicaid Program:	LTC Medical criteria	Effective Date:	01/20/12
Revision Number:	1	Last Review Date:	01/18/2013
Reviewed By:	Clinical Advisory Committee	Next Review Date:	01/20/14
Approved By:	Medicaid Medical Director	Approved Date:	02/17/2012
Approved By:	DHS Policy Staff	Approved Date:	02/17/2012

Criteria:

In order to approve skilled level of care for the waiver programs, the following conditions must be met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with general provisions for all Medicaid providers and services as described within 441-79.9.
3. Documentation submitted for review must indicate that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that addresses identified deficit areas.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services provided by, or under the supervision of medical personnel as described above.
 - f. Skilled nursing services needed and provided seven days a week or skilled rehabilitation services needed and provided at least five days a week.

Change History:

Change Date:	Changed By:	Description of Change:	New Version Number:

Nurse’s Desk Guide for Criteria:

1) Cognitive, Mood and Behavior Patterns

LEVEL OF CARE	EVALUATION OF SERVICES PROVIDED
INTERMEDIATE (A - F)	<p>The following circumstances exist:</p> <ul style="list-style-type: none"> A. Short/long term memory problem B. Moderately/severely impaired cognitive skills for daily decision-making C. Devices and/or restraints used. Documentation reflects assessment for the least restrictive restraint D. Behavioral symptoms, i.e., wandering, verbally/physically abusive, socially inappropriate/disruptive, and/or resists care. A behavior management program is addressed on care plan E. Comatose (persistent vegetative state/no discernible consciousness) F. Indicators of depression, anxiety, or sad mood exhibited.
SKILLED CARE (G)	<ul style="list-style-type: none"> G. Formal, supportive psychiatric services. <u>Condition is not stable.</u> Documentation reflects daily assessment and evaluation by professional nursing staff. Structured environment provided for resident’s/other’s safety. (Refer to physician reviewer if this is the only skilled criterion used. Review in 7 days for continued stay at this level of care.)

2) Physical Functioning - Mobility

LEVEL OF CARE	EVALUATION OF SERVICES PROVIDED
INTERMEDIATE (A - F)	<p>The following circumstances exist:</p> <ul style="list-style-type: none"> A. Transfer, walking, and/or locomotion performance requiring supervision/set-up help by staff with/without device (e.g., slide board, trapeze, cane, walker, brace, prosthesis, wheelchair) B. Transfer, walking, and/or locomotion performance requiring limited assistance by staff through set-up help or physical assistance with/without device C. Transfer, walking, and/or locomotion performance requiring extensive assistance by staff through set-up help or physical assistance with/without device D. Transfer, walking, and/or locomotion performance requiring total assistance by staff through set-up help or physical assistance with/without device E. Bedfast all or most of the time F. Quadriplegia
SKILLED CARE (R-Z)	<ul style="list-style-type: none"> R. Physical therapy program with restorative goals (i.e., strengthening, gait training, stair climbing, and transfer) provided daily by or under the direction/ supervision of a licensed physical therapist. Daily documentation indicates progress S. Continuous skin/skeletal traction

	<p>T. Physical therapy with restorative goals for muscle retraining and strengthening (i.e., active/passive range of motion, weights, electric or tactile stimulation, resistive exercises, etc.) provided daily by or under the direction/supervision of licensed physical therapist. Daily notes must be present</p> <p>U. Occupational therapy with restorative goals for gross/fine motor muscle retraining including upper extremity, sitting, balance, etc., provided on a daily basis by an occupational therapist. Daily progress notes must be present.</p> <p>V. Physical therapy with maintenance goals provided daily by or under the direction/supervision of a licensed physical therapist. Evidence that without this maintenance therapy; the resident's functional status would deteriorate</p> <p>W. Physical therapy program provided less than daily by or under the direction/supervision of a licensed therapist. (If this is the only skilled criterions met refer to physician reviewer.)</p> <p>X. Other services provided by physical therapy, i.e., ROM testing, evaluation, stretching, ultrasound, shortwave, microwave, diathermy, hot packs, infrared treatment, paraffin bath, whirlpool bath. (If only criterion met, it must be performed on a daily basis. If not, refer to physician reviewer.)</p> <p>Y. Physical therapy program with restorative goals (i.e., strengthening, gait training, stair climbing, transfer techniques) provided daily by or under the direction/ supervision of a licensed physical therapist. Daily documentation indicates progress</p>	
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3) Skin Condition

LEVEL OF CARE	EVALUATION OF SERVICES PROVIDED
INTERMEDIATE (A - D)	<p>The following circumstances exist:</p> <p>A. Non-blanchable erythema of intact skin.</p> <p>B. Pressure/stasis ulcer(s), skin lesion(s), or surgical wound(s) present with partial thickness skin loss involving epidermis and/or dermis. Licensed nursing staff administers treatment(s) as prescribed by the physician.</p> <p>C. Pressure/stasis ulcer(s), skin lesion(s), or surgical wound(s) present with full thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to underlying fascia, and/or extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structure (tendon, joint capsule, etc.). Licensed nursing staff administers less than daily treatment(s) as prescribed by the physician.</p> <p>D. Other skin problems or lesion(s) present. Licensed nursing staff administers treatment(s) as prescribed by the physician. (May include drainage tubes, incisions, psoriasis, etc.) Area is not open.</p>
SKILLED CARE (R - T)	<p>R. Wide spread skin disorder, pressure/stasis ulcer(s), skin lesion(s), or surgical wound(s) present with full thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to underlying fascia, and/or extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structure (tendon, joint capsule, etc.). Licensed nursing staff administers daily treatment(s) as prescribed by the physician until skin is intact.</p> <p>S. Strict isolation due to contagious infection, disease, or immune deficiency requiring professional monitoring and evaluation for prevention of cross-contamination.</p> <p>T. Individualized teaching and training program initiated by licensed nursing staff to enable resident/caregiver to learn dressing change techniques, wound care procedures, and/or preventive skin care. Review for response to teaching in 7 days if this is the only criterion met.</p> <p>U. Individualized preventative/rehabilitative plan of care for A - T should include:</p> <ul style="list-style-type: none"> ● protective/preventive skin care ● turning/repositioning schedule ● pressure reduction devices ● nutritional/hydration program ● daily skin inspection ● weekly assessment of healing process

4) Pulmonary Status

LEVEL OF CARE	EVALUATION OF SERVICES PROVIDED
INTERMEDIATE (A - E)	<p>The following circumstances exist:</p> <ul style="list-style-type: none"> A. Experiences respiratory distress and oxygen administered by nursing staff on a PRN basis or at specified time intervals B. Experiences respiratory distress and oxygen administered by nursing staff on a continuous basis C. Inhalative treatments, incentive spirometer, IPPB treatments, or chest percussion therapy administered by nursing staff as prescribed by the physician. D. Suctioning by licensed nursing staff on a PRN basis (less than daily). E. Routine tracheostomy care by licensed nursing staff for resident in stable condition.
SKILLED CARE (R - U)	<ul style="list-style-type: none"> R. Naso-pharyngeal and/or tracheostomy suctioning by licensed professional staff provided daily or more frequently. S. Respiratory therapy required for maintenance of the resident's respiratory status provided daily by or under the direction of a licensed respiratory therapist. Evidence that without this maintenance therapy; the resident's functional status would deteriorate. T. Ventilator/respirator is required on an intermittent or continuous basis for maintenance of the resident's pulmonary status. NOTE: To qualify for use of T, documentation must include: <ul style="list-style-type: none"> - ventilator-dependent at least 6 hours daily - inappropriate for home care - failed attempts at weaning or inappropriate weaning - the facility is on the DHS ventilator-dependent unit list U. Individualized teaching and training program initiated by licensed professional staff to enable resident/caregiver to learn to use and care of respiratory equipment and/or administration of treatment (i.e., oxygen, tracheostomy care, ventilator, etc.). Review for response to teaching in 7 days if this is the only criterion met. V. Naso-pharyngeal and/or tracheostomy suctioning by licensed professional staff provided daily or more frequently. W. Respiratory therapy required for maintenance of the respiratory status provided daily by or under the direction of a licensed respiratory therapist. Evidence that without this maintenance therapy the resident's functional status would deteriorate. X. Ventilator/respirator is required on an intermittent or continuous basis for maintenance of the resident's pulmonary status. NOTE: To qualify for use of T, documentation must include: <ul style="list-style-type: none"> - ventilator-dependent at least 6 hours daily - inappropriate for home care - failed attempts at weaning or inappropriate weaning - the facility is on the DHS ventilator-dependent unit list Y. Individualized teaching and training program initiated by licensed professional staff to enable resident/caregiver to learn to use and care of respiratory equipment and/or administration of treatment (i.e., oxygen, tracheostomy care, ventilator, etc.). Review for response to teaching in 7 days if this is the only criterion met.

5) Contenance

LEVEL OF CARE	EVALUATION OF SERVICES PROVIDED
INTERMEDIATE (A - F)	<p>The following circumstances exist:</p> <ul style="list-style-type: none"> A. Occasionally or frequently incontinent and/or involuntary requiring staff assistance. B. Totally incontinent and/or involuntary requiring staff assistance. C. Daily nursing care and evaluation of elimination status for resident with ostomy/ileal conduit. D. Indwelling urethral/suprapubic catheter requiring less than daily irrigation by licensed nursing staff as ordered by the physician. Daily perineal and catheter care provided by nursing staff. E. Intermittent catheterization performed less than daily by licensed nursing staff as ordered by the physician. F. CAPD performed by licensed nursing staff as ordered by the physician.
SKILLED CARE (R - W)	<ul style="list-style-type: none"> R. Intermittent catheterization performed daily by licensed nursing staff as ordered by the physician. S. Indwelling urethral/suprapubic catheter present requiring daily irrigation by licensed nursing staff as specifically ordered by the physician. T. Nephrostomy tube(s) present requiring daily dressing change(s), stoma care, and monitoring of tube position by licensed nursing staff. U. Suprapubic catheter present in early post-operative period requiring daily care and evaluation by licensed nursing staff. After initial 7 days, refer to physician reviewer for continued stay approval. V. Colostomy/ileostomy/ileo conduit present in early post-operative period requiring daily care and evaluation by licensed nursing staff. After initial 7 days, refer to physician reviewer for continued stay approval. <p>Individualized teaching and training program initiated by licensed nursing staff to enable resident/caregiver to learn care of bowel/bladder appliances and equipment and/or administration of treatment (i.e., catheterization, dialysis, stoma care, etc.). Review for response to teaching in 7 days if this is the only criterion met.</p>

7) Physical Functioning - Eating

LEVEL OF CARE	EVALUATION OF SERVICES PROVIDED
INTERMEDIATE (A - E)	The following circumstances exist: A. Supervision with set-up help required with eating. Limited assistance with eating. B. Extensive assistance with eating. C. Total assistance with eating D. Professional assessment and intervention for oral problems, weight changes, or nutritional problems.
SKILLED CARE (R - V)	R. Occupational or speech therapy plan to retain or establish new skill patterns in eating. Services provided daily by or under the direction/supervision of occupational or speech therapist. Review for progress within 7 days with a physician reviewer if only skilled criterion met. S. Physician ordered plan to remove feeding tube and reintroduce oral foods. Review for progress within 7 days. T. Hyperalimentation administered by licensed nurses. U. Nutritional status maintained through intravenous infusions administered by licensed nurses. V. Naso-gastric, gastrostomy, pharyngotomy, or jejunostomy tube feedings provided for resident when oral intake is inadequate to meet the resident's nutritional needs, including 26 percent of daily calories and minimum of 501 ml. fluid per day.

8) Medications

LEVEL OF CARE	EVALUATION OF SERVICES PROVIDED
INTERMEDIATE (A - D)	The following circumstances exist: A. Insulin administered by nursing staff with set dosages. B. Central or peripheral venous line or port in place. Irrigated less than daily. Licensed nursing staff available on a 24-hour basis to assess for complications. C. Insulin administered per sliding scale with set parameters. D. Medications administered subcutaneously (excluding insulin) at least daily.
SKILLED CARE (R - V)	R. Frequent lab values. If this is the only skilled criterion met, refer to physician. S. Medications administered intravenously at least daily. T. Medications administered intramuscularly at least daily. U. Insulin administered requiring at least daily adjustment determined by blood glucose levels and contact with physician. V. Medications administered requiring physician monitoring and appropriate to physician reviewer. W. Medications, chemotherapy, or blood products administered daily via central venous line(s) or port(s).

9) Communication/Hearing/Vision Patterns

LEVEL OF CARE	EVALUATION OF SERVICES PROVIDED
INTERMEDIATE (A - D)	The following circumstances exist: A. Hearing impaired and appliances (if used) are not helpful. B. Unable to communicate needs adequately without communication devices. C. Vision impaired and glasses (if used) are not helpful. D. Speech therapy is provided on a less than daily basis.
SKILLED CARE (R)	R. Speech - language pathology and/or audiology services are provided at least daily and in conjunction with other skilled services. If this criterion is used alone, refer to physician reviewer.

10 Limited Stay NF

LEVEL OF CARE	EVALUATION OF SERVICES PROVIDED
INTERMEDIATE OR SKILLED	The following circumstances exist: Member meets LOC for either NF or SNF and A. Member is being admitted to the NF directly from a hospital. B. Member resided in their own home or apartment prior to the hospitalization. C. Member had been receiving waiver services prior to hospital admission. D. Member making a new application for waiver services during this NF stay.

References Used:

Change History:

Change Date:	Changed By:	Description of Change:	New Version Number:



Level of Care Certification for Facility

PLEASE PRINT OR TYPE

Fax form to: Iowa Medicaid Enterprise Medical Services (515) 725-1349
 Medical professional completing this form must provide a copy to the admitting facility.

Today's Date / /	Iowa Medicaid Member Name	Social Security or State ID #	Birth Date / /
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Medical Professional completing form (MD, DO, PA-C or ARNP required)

Name	Telephone Number (10 digits)
Address, City, State, Zip	
Admit to: <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Intermediate Care Facility for the Intellectually Disabled	
Discussion occurred regarding alternatives to facility placement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of discussion: / /	
Anticipated admission date: / /	Anticipated length of stay: _____ days Time limited stay? <input type="checkbox"/> Yes <input type="checkbox"/> No

Facility Information (NF or ICF/ID)

Facility Name	
Address, City, State, Zip	
Telephone Number (10 digits)	Fax Number (10 digits)

ATTACH MEDICATION AND DIAGNOSES LISTS (WITH ICD CODES) SEPARATELY

Skilled Nursing Needs: Check all boxes that apply.

<p>Therapies provided 5 days a week:</p> <input type="checkbox"/> Physical <input type="checkbox"/> Occupational <input type="checkbox"/> Speech Duration expected: _____	<p>Medications provided daily:</p> <input type="checkbox"/> Intravenous <input type="checkbox"/> Intramuscular Drug name, dose, length of treatment: _____	<p>Stoma care in early postop phase requiring daily care:</p> <input type="checkbox"/> Colostomy <input type="checkbox"/> Ileoconduit <input type="checkbox"/> Suprapubic catheter site <input type="checkbox"/> Ileostomy <input type="checkbox"/> Nephrostomy
<p>Respiratory therapy daily:</p> <input type="checkbox"/> Nasotracheal suctioning <input type="checkbox"/> Tracheostomy care <input type="checkbox"/> Ventilator at least 8 hours/day	<p>Tube feeding:</p> <input type="checkbox"/> More than 26% of calorie intake per day/minimum of 501 cc/day Name/brand, dose, length of treatment: _____	<p>Wound care for at least Stage 4</p> <input type="checkbox"/> Sterile dressing change daily <input type="checkbox"/> Wound vac care

Functional Limitations: Check all boxes that apply.

<p>Cognition</p> <input type="checkbox"/> No problem <input type="checkbox"/> Language barrier <input type="checkbox"/> Short/long term memory problem <input type="checkbox"/> Problems with decision making <input type="checkbox"/> Interferes with ability to do ADLs BIMS score (if applicable) _____	<p>Dressing</p> <input type="checkbox"/> Independent <input type="checkbox"/> Supervision or cueing needed <input type="checkbox"/> Physical assistance needed Frequency of needed assistance: <input type="checkbox"/> 1-2 x weekly <input type="checkbox"/> 3-4 x weekly <input type="checkbox"/> >4 x weekly <input type="checkbox"/> Age appropriate	<p>Medications</p> <input type="checkbox"/> Independent <input type="checkbox"/> Requires setup <input type="checkbox"/> Administered by others <input type="checkbox"/> Insulin, set dosage <input type="checkbox"/> Insulin, sliding scale <input type="checkbox"/> Frequent lab values
<p>Ambulation</p> <input type="checkbox"/> Independent <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Motorized scooter <input type="checkbox"/> Needs human assistance <input type="checkbox"/> Transfer assist <input type="checkbox"/> Restraint used	<p>Behaviors</p> <input type="checkbox"/> None <input type="checkbox"/> Requires 24-hour supervision <input type="checkbox"/> Noncompliant <input type="checkbox"/> Destructive or disruptive <input type="checkbox"/> Repetitive movements <input type="checkbox"/> Antisocial <input type="checkbox"/> Aggressive or self-injurious <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression	<p>Bathing/Grooming</p> <input type="checkbox"/> Independent <input type="checkbox"/> Independent with assistive devices <input type="checkbox"/> Supervision or cueing needed <input type="checkbox"/> Physical assistance needed Frequency of needed assistance: <input type="checkbox"/> 1-2 x weekly <input type="checkbox"/> 3-4 x weekly <input type="checkbox"/> >4 x weekly <input type="checkbox"/> Age appropriate
<p>Skin</p> <input type="checkbox"/> Intact <input type="checkbox"/> Ulcer - Stage _____ <input type="checkbox"/> Open wound <input type="checkbox"/> Daily treatment <input type="checkbox"/> Treatment as needed	<p>Elimination</p> <input type="checkbox"/> Continent <input type="checkbox"/> Bladder incontinence <input type="checkbox"/> Bowel incontinence <input type="checkbox"/> Urinary catheter <input type="checkbox"/> Chronic colostomy/ostomy <input type="checkbox"/> Chronic nephrostomy <input type="checkbox"/> Age appropriate <input type="checkbox"/> Physical assistance needed	<p>Respiratory</p> <input type="checkbox"/> No issue <input type="checkbox"/> O2 use daily <input type="checkbox"/> O2 as needed <p>Eating</p> <input type="checkbox"/> Independent <input type="checkbox"/> Assistive devices <input type="checkbox"/> Requires human assistance <input type="checkbox"/> Age appropriate

Additional comments:

Signature with title of medical professional completing certification form (MD, DO, PA-C, ARNP):

Nursing Facilities Only

Did the member come to the NF from a recent acute hospital stay? Yes No

Member's living situation prior to acute hospitalization:
 Own residence Family/relative home
 Other (describe):

Will member be applying for HCBS waiver services? Yes No

ICF/ID Facilities Only: To be completed by admitting facility or case manager.

Name of Facility Contact Person	Telephone Number (10 digits)		
D&E (preadmission evaluation) date: / /	Date psychological evaluation completed (<i>must be completed before admission but no more than 3 months prior to admission</i>): / /		
ID diagnosis (mild, moderate, severe) or related condition:	FSIQ Score: _____		
Full Name of Diagnosing Psychologist			
<p>Check areas in which the member would benefit from ICF/ID programming/treatment:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Ambulation and mobility <input type="checkbox"/> Musculoskeletal disabilities/paralysis <input type="checkbox"/> Activities of daily living (ADLs) <input type="checkbox"/> Elimination <input type="checkbox"/> Eating skills </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Sensorimotor <input type="checkbox"/> Intellectual/vocational/social <input type="checkbox"/> Maladaptive behaviors <input type="checkbox"/> Health care <input type="checkbox"/> Alternative level of care assessment </td> </tr> </table>		<input type="checkbox"/> Ambulation and mobility <input type="checkbox"/> Musculoskeletal disabilities/paralysis <input type="checkbox"/> Activities of daily living (ADLs) <input type="checkbox"/> Elimination <input type="checkbox"/> Eating skills	<input type="checkbox"/> Sensorimotor <input type="checkbox"/> Intellectual/vocational/social <input type="checkbox"/> Maladaptive behaviors <input type="checkbox"/> Health care <input type="checkbox"/> Alternative level of care assessment
<input type="checkbox"/> Ambulation and mobility <input type="checkbox"/> Musculoskeletal disabilities/paralysis <input type="checkbox"/> Activities of daily living (ADLs) <input type="checkbox"/> Elimination <input type="checkbox"/> Eating skills	<input type="checkbox"/> Sensorimotor <input type="checkbox"/> Intellectual/vocational/social <input type="checkbox"/> Maladaptive behaviors <input type="checkbox"/> Health care <input type="checkbox"/> Alternative level of care assessment		
Signature with title of person completing ICF/ID information:			

Instructions for Level of Care for Facility

Purpose Form 470-4393, *Level of Care Certification for Facility*, provides a mechanism for a medical professional (MD/DO/ARNP/PA-C) to report level of care needs for a Medicaid member's admission or change in condition for level of care.

Source This form is available on the DHS website under Provider Forms.

Completion A provider (MD/DO/ARNP/PA-C) must complete the form when a:

- Medicaid member is going to be admitted to a NF or ICF/ID.
- Medicaid member residing in a NF or ICF/ID has a significant change in condition.

Distribution Providers fax the certification for level of care form to the IME Medical Services Unit (515-725-1349) and provides a copy to the admitting facility.

The form may be faxed by the medical professional completing the form or by others involved in arranging the services (facility staff, hospital discharge planner, case manager or family member). The IME Medical Services Unit will make a level of care determination upon receipt of the form.

Data **Today's Date:** The date the form is completed (MM/DD/YYYY).

Iowa Medicaid Member Name: The Medicaid member's first name, middle initial, and last name as it appears on the eligibility card.

Social Security or State ID #: The member's social security number or state identification number as it appears on the eligibility card.

Birth Date: The Medicaid member's birth date (MM/DD/YYYY) as it appears on the eligibility card.

Medical Professional Section

Name, Telephone Number with Area Code, and Address: Specific information about the medical professional filling out the form.

Admit to: The type of facility, attestation of, and date of discussion about alternatives to facility placement.

Anticipated admission date: The expected or actual date of admission to the facility (MM/DD/YYYY) and anticipated stay.

Facility Information

Facility Name, Address, Telephone and Fax Numbers with Area Code: The facility specific information related to the level of care certification.

ATTACH MEDICATION AND DIAGNOSES LISTS (WITH ICD CODES) SEPARATELY: Provide current medication and diagnoses lists as separate attachments.

Skilled Nursing Needs: Check all boxes that apply to the member regarding skilled nursing needs for therapy, medications, wound care, stoma care, ventilator, tracheostomy care or tube feedings. Also complete functional limitations section below.

Functional Limitations: Check all boxes that apply to the member's functional abilities.

Additional comments: Additional pertinent comments from the medical professional.

Signature with title of medical professional (MD/DO/PA/ARNP) completing the form.

Nursing Facilities Only: Previous hospital placement, previous living situation, and plan for waiver application.

ICF/ID Facilities Only: Facility contact name and telephone number, preadmission evaluation date, ID diagnosis with FSIQ score, full name of diagnosing psychologist. Check all areas in which the member would benefit from ICF/ID admission or subsequent service.

Signature of person completing ICF/ID information.

RFP Reference:

6.2.6.2

Interfaces:

ISIS
OnBase
MQUIDS

Attachments:

N/A

Med - Nursing Facility Level of Care Appeals Determinations

Purpose: A Medicaid member who disagrees with a Medicaid decision regarding Medicaid services has the right to appeal within 30 days of the date of the notice of decision letter by contacting the local DHS office, by writing a letter to DHS Appeals Section or by filing on line at http://www.dhs.state.ia.us/dhs/appeals/appeal_decision.html. The notice of decision letter contains instruction on how to request an appeal. Medical Services provides testimony for assigned appeal hearings.

Identification of Roles:

Review Assistant (RA) – provides program support.

Review Coordinator (RC) – performs assessments and provides education to members regarding care alternatives.

Manager – provides training and oversight in the field, tracks performance standards, produces reports for medical services and conducts internal quality control for review decisions.

Clinical Assistant to the Medicaid Medical Director (CAMD) - review levels of care or quality of care concerns and makes medical necessity determinations and approves corrective action plan requests that include quality of care concerns.

Medicaid Medical Director (MMD) – provides level of care determinations.

Performance Standards:

- Complete 100 percent of LOC determinations for admissions within five business days of receipt of complete information.
- Complete 100 percent of LOC determinations for continued stay reviews within ten business days of receipt of complete information

Path of Business: For specific operational procedures related to appeals completed by Medical Services on behalf of DHS, see Med Srv Policy Support Appeals located online in the IME Library Resource.

Step 1: The review assistant (RA) will record this information in MQUIDS.

- a. This includes the name of the judge, the date of the decision and the outcome of the appeal with any notes pertinent to the case.

Only PRs make denial decisions. Denial decisions are completed in writing by letter. PRs include licensed health care professions in the same category as the attending provider. Denials made by the CAMD will be reviewed by the MMD. Notice of the availability of the peer to peer conversation is included in the letter. The manager will arrange for the peer to peer conversation within one business day of the request unless there are extenuating circumstances outside of Medical Services' control. Notice of the availability of the peer-to-peer conversation is included on the IME website <http://www.ime.state.ia.us>

Step 2: The RA will forward the outcome to the manager who will notify the RC by email of outcome of the hearing and RC will update ISIS if needed.

Forms/Reports:
NF Level of Care Denial Notice of Action (NOA)

Iowa Department of Human Services

**NOTICE OF DECISION:
 SERVICES**

County	Date
Case #	Effective Date

Member name and address

ACTION

- Approval
- Denial
- Review
- Change in Service
- Reduction
- Cancellation

<p>A level of care review for your nursing facility ^e(admission or continuing) stay has been completed. After reviewing the medical record information supplied by facility staff and providing the attending physician the opportunity to submit additional information, Medical Services determined that we are unable to approve the ^e(admission or continuing) stay for you based on the information submitted.</p> <p>Insert PR rationale: ^</p>
<p>Manual or Rule References: Iowa Administrative Code (IAC) 441 Chapter 79.9(2) and 81.3(1) The attending physician may request a peer-to-peer conversation with the peer reviewer who made the decision by calling the telephone number listed below.</p>
<p>Fees: You will be responsible for paying for part of service. The fee will be per . You should make arrangements to pay this directly to .</p>

CONFERENCE: If you do not agree with the decision, you may discuss the decision and your situation with the agency staff, obtain an explanation of the action and present information to show that the action is incorrect. This conference does not in any way diminish your right to a hearing described on the back of this page. You may speak for yourself or be represented by legal counsel, a friend, or other person. If you have trouble understanding this notice, you may call **Iowa Legal Aid** at 1-800-532-1275. If you live in Polk County, call 243-1193.

REAPPLICATION: If your application has been denied or your assistance has been canceled, you have the right to reapply at any time.

Worker's Signature Iowa Medicaid Enterprise Medical Services	Telephone Number 800-383-1173 or locally 515-256-4623.
Office Address P.O Box 36478 Des Moines, IA 50315	

You Have the Right to Appeal

What is an appeal?

An **appeal** is asking for a hearing because you do not like a decision the Department of Human Services (DHS) makes. You have the right to file an appeal if you disagree with a decision. You do not have to pay to file an appeal. [441 Iowa Administrative Code Chapter 7].

How do I appeal?

Filing an appeal is easy. You can appeal in person, by telephone or in writing for Food Assistance or Medicaid. You must appeal in writing for all other programs. To appeal in writing, do **one** of the following:

- Complete an appeal electronically at <https://dhssecure.dhs.state.ia.us/forms/>, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

How long do I have to appeal?

For Food Assistance or Medicaid, you have 90 calendar days to file an appeal from the date of a decision. For all other programs, you must file an appeal:

- Within 30 calendar days of the date of a decision or
- Before the date a decision goes into effect

If you file an appeal more than 30 but less than 90 calendar days from the date of a decision, you must tell us why your appeal is late. If you have a good reason for filing your appeal late, we will decide if you can get a hearing.

If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Can I continue to get benefits when my appeal is pending?

You may keep your benefits until an appeal is final or through the end of your certification period if you file an appeal:

- Within 10 calendar days of the date the notice is received. A notice is considered to be received 5 calendar days after the date on the notice or
- Before the date a decision goes into effect

Any benefits you get while your appeal is being decided may have to be paid back if the Department's action is correct.

How will I know if I get a hearing?

You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. This letter will tell you why you did not get a hearing. It will also explain what you can do if you disagree with the decision to not give you a hearing.

Can I have someone else help me in the hearing?

You or someone else, such as a friend or relative can tell why you disagree with the Department's decision. You may also have a lawyer help you, but the Department will not pay for one. Your county DHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to:
Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 or via email contactdhs@dhs.state.ia.us

(Food Assistance only) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).

Medical Services-Long Term Care Case Summary

Appeal Summary for _____, State ID _____

On date LOC from submitted, Iowa Medicaid Enterprise (IME), Medical Services received a request for approval of intermediate (nursing facility) level of care on behalf of Members full name. The level of care request is necessary to secure NF services for Members name. The information submitted did not support approval of What level of care requested level of care for Continued or admission participation in the NF program.

The last review was completed on Date of last review if it is a CSR - delete if admit. IME Medical Services was informed member name required why were they approved last year. All of the information submitted has indicated he/she is able to complete his/her own personal cares without supervision, cueing, or prompting and any other info that helps appeal like driving, working, etc

The level of care form (D1) was completed by Dr's name and submitted for review. The information provided by Dr's name indicated Member's name is an age in years-year-old gender who List here what the certification form shows The diagnoses at the time of the review were submitted for review and are included in Exhibit D.

Throughout the course of the review, the office of attending provider, Dr's name, and the NF were contacted to discuss the information submitted during the review process and were given the opportunity to submit additional information. Dr's name nurse reported Describe all the things you learned from the Dr. office here in a clear and well written manner

Information was submitted from Here is what you describe any information you obtained from other providers.

IME Medical Services gathers information related to the criteria from a members' physician or other providers at the time of the eligibility review. The review is initially conducted by a nurse reviewer who may approve if the member requires daily supervision or prompting with both bathing and dressing.

The criteria used by Medical Services are physician-developed criteria and are approved by the Department of Human Services. The criteria for nursing facility level of care indicates nursing facility level of care can be approved if the member requires at a minimum daily supervision or prompting with both dressing and personal hygiene; i.e., criterion number six. This would need to be provided on a daily basis by the physical assistance of at least one person for dressing and personal hygiene. If the member does not meet criterion in number six, the case must be referred to a physician reviewer for a level of care determination. There was no evidence provided that indicated this member met criteria for nursing facility level of care.

If the nurse reviewer is unable to match a member's functional ability to the criteria, the review is submitted to a physician reviewer for a level of care determination. The physician relies on medical expertise and judgment to determine the medical necessity of approving a member to receive NF services. Medical eligibility for NF/waiver services shall be consistent with the diagnosis and treatment of the members condition, be in accordance with standards of good medical practice, be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver, and be the least costly type of service which

would reasonably meet the medical need of the patient.¹ Services must be needed on a daily basis.ⁱⁱ

What is Nursing Facility level of care? A nursing facility means an institution or a distinct part of an institution housing, which is primarily engaged in providing health-related care and services, including rehabilitative services, but which is not engaged primarily in providing treatment or care for mental illness or mental retardation.ⁱⁱⁱ Nursing Facility level of care is provided for those who have the presence of a physical or mental impairment which restricts the ability to perform the essential activities of daily living; bathing, dressing, and personal hygiene and impedes the capacity to live independently. The member's physical or mental impairment is such that self-execution of the required nursing care is improbable or impossible. Therefore, the member would require nursing facility placement to perform the health-related services.

Physician review was completed by Copy in Pr credentials

The nurse reviewer submitted the case information to PR name for a medical necessity determination on How many times did it go to PR occasions. The physician reviewer did not approve the level of care for Members name based on the following rationale:

- The level of care form and further conversations with Dr. Name nurse, and information from other providers and the case manager, indicate the member List PR rationale here. Each rationale should have new point.

The focus of the level of care review is to determine if Members name limitations rise to the level at which he/she would require nursing facility placement. All documentation and information obtained during the review process indicates Members name is independent with his/her personal cares. Member name did not meet the criteria requiring assistance with both bathing and dressing. There was no indication that he/she has physical care needs as such that self-execution of the required nursing care is improbable or impossible. In addition, Member name did not meet the medical necessity determination for nursing facility level of care. Mr./Ms. member last name care needs can be met at a lower level of care or by other programs that may be available to him/her.

¹ Iowa Administrative Code 441-79.9(2)

² Iowa Code 135C.1(13); Iowa Administrative Code 441-81.1; Sec. 1919. [42 U.S.C. 1396r]; 42 CFR 440.40

RFP Reference:

6.2.6.2

Interfaces:

ISIS

OnBase

MQUIDS

Attachments:

N/A

Med - Nursing Facility Internal Quality Control

Purpose: Internal quality control (IQC) is a peer to peer review process completed on a percentage of LOC reviews from the previous month.

Identification of Roles:

Review Assistant (RA) – provides program support.

Review Coordinator (RC) – performs assessments and provides education to members regarding care alternatives.

Manager – provides training and oversight in the field, tracks performance standards, produces reports for medical services and conducts internal quality control for review decisions.

Performance Standards:

- Complete 100 percent within five business days of receipt of complete information.
- Complete 100 percent of LOC determinations for continued stay reviews within ten business days of receipt of complete information.

Path of Business Procedure:

IQC Monthly

Step 1: On the 5th business day of the month, the manager or designee will randomly select one admission and one SSR LOC reviews from the monthly performance reports from each of the 6 RCs completing NF reviews and a total of 6-8 PACE reviews from the RCs completing PACE LOC reviews.

Step 2: The manager will send each of the 6 RCs the SID# and names of the individuals the RC is to complete an IQC review.

Step 3. The RC will do a search on Onbase to bring up the LOC certification submitted by the provider, pull up the case review in MQUIDS, and check ISIS.

- ISIS will be checked for accuracy of dates of service and appropriate response to LOC or denial with appropriate comments in ISIS.
- IQC form will include Yes or No responses to the questions:
 - Is the NF correctly identified?
 - Is the review type, admission or SSR correctly identified?
 - Have the criteria for LOC been correctly applied based upon information on the LOC form or documentation of contact with provider on Activity page?
 - Were the criteria filled in completely on MQUIDS based upon the information gathered?
 - Was the correct LOC recorded on MQUIDS and ISIS?
 - Was the case correctly referred to PR?
 - Was the correct length of stay approval recorded on MQUIDS and ISIS?
 - Did the RC correctly utilize the Activity page for contacts with provider?
 - Were the diagnoses and medications recorded on MQUIDS?

IQC NF and PACE

Date

RC doing IQC review:

RC having completed the LOC review:

Type of IQC review: ___ NF Admission ___ PACE Admission

 ___ NF SSR ___ PACE SSR

Yes	No	For all reviews	Comments
		1. Is the NF/PACE program correctly identified?	
		2. Is the review type Admission or SSR correctly identified?	
		3. Have the criteria for LOC been correctly applied based upon information on the LOC form or the documentation on the Activity page of contract with provider?	
		4. Were the criteria filled in completely on MQUDIS based upon the information gathered?	
		5. Was the correct LOC recorded on MQUIDS and ISIS?	
		6. Was the case correctly referred to PR?	
		7. Was the correct length of stay approved recorded on MQUIDS and ISIS?	
		8. Did the RC correctly utilize the Activity page for contacts with provider?	
		9. Were the diagnoses and medications recorded on MQUIDS?	

Step 4: Where there appropriate referrals to PR for determining LOC. Overall, feedback from the monthly IQC will be provided to the RC's. Quarterly during the coaching session, the manager will discuss with each RC their IQC error or inconsistency rate and their productivity rate in comparison with others on the team.

Forms/Reports:

Reports will be submitted to DHS in format requested on a monthly, quarterly or annual basis.

RFP Reference:

6.2.6.2

Interfaces:

ISIS
OnBase
MQUIDS

Attachments:

N/A

MED - Nursing Facility Business Disruption Plan

Purpose: In the event that the NF assessment procedure is disrupted due to power outages that impact normal systems operation for longer than two hours, the following paper procedures will be followed.

Performance Standards:

- Complete 100 percent of LOC determinations for admissions within five business days of receipt of complete information.
- Complete 100 percent of LOC determinations for continued stay reviews within ten business days of receipt of complete information.

Path of Business Procedure:

Step 1: The RA will receive the assessment forms by fax or mail and will forward the forms in the mail to the RC.

Step 2: The RA will log calls and capture the following information:

- a. Date received
- b. Member name
- c. Member SID number
- d. Caller's name
- e. Services requested
- f. RC assigned

Step 3: The RC will follow the procedure outlined to complete the LOC certification form. Documentation into ISIS will be completed using the same timelines from when the system is restored.

Step 4: The RC will document requests for LOC determinations on paper documentation for the following data elements:

- a. Date received
- b. Member name
- c. Member SID number
- d. Type of request
- e. Date additional information requested
- f. Date additional information received
- g. Date of PR
- h. Status of request
- i. Date of completion of review

Forms/Reports:

N/A

RFP Reference:

6.2.6.2

Interfaces:

ISIS
OnBase
MQUIDS

MED - Nursing Facility Assessments Urgent Request

Purpose: The RC will discuss with their manager and log the request.

Identification of Roles:

Review Coordinator (RC) – enter urgent care request in Individualized Services Information System and urgent request tracking log.

Manager - Report the number of urgent care requests and timeliness quarterly to corporate Utilization Review Accreditation Committee (URAC) compliance staff.

Director - Ensure the percent of timely urgent request are reported on the URAC compliance dashboard quarterly.

Path of Business Procedure:

Step 1: Urgent requests for Level of care services will be reviewed and a decision rendered and communicated in no less than 72 hours from receipt of the request.

Step 2: A request is urgent if the situation poses an immediate threat to the health and safety of the Medicaid member or if the attending physician, member or family member indicates that the need is urgent. This time frame includes holidays and weekends.

Step 3: When an urgent request is received, the staff member will confer with manager and log the request on the spreadsheet located at MedSrv/Urgent Requests/Urgent Request Tracking.

Form/Reports:

Urgent Request Tracking

Program	Review Coordinator	Member L. Name	Member F. Name	SID	Requestor	Initial Date of Service	Date & Time of Request	Decision	Date & Time of Decision	No. of Hrs	Notes

RFP Reference:

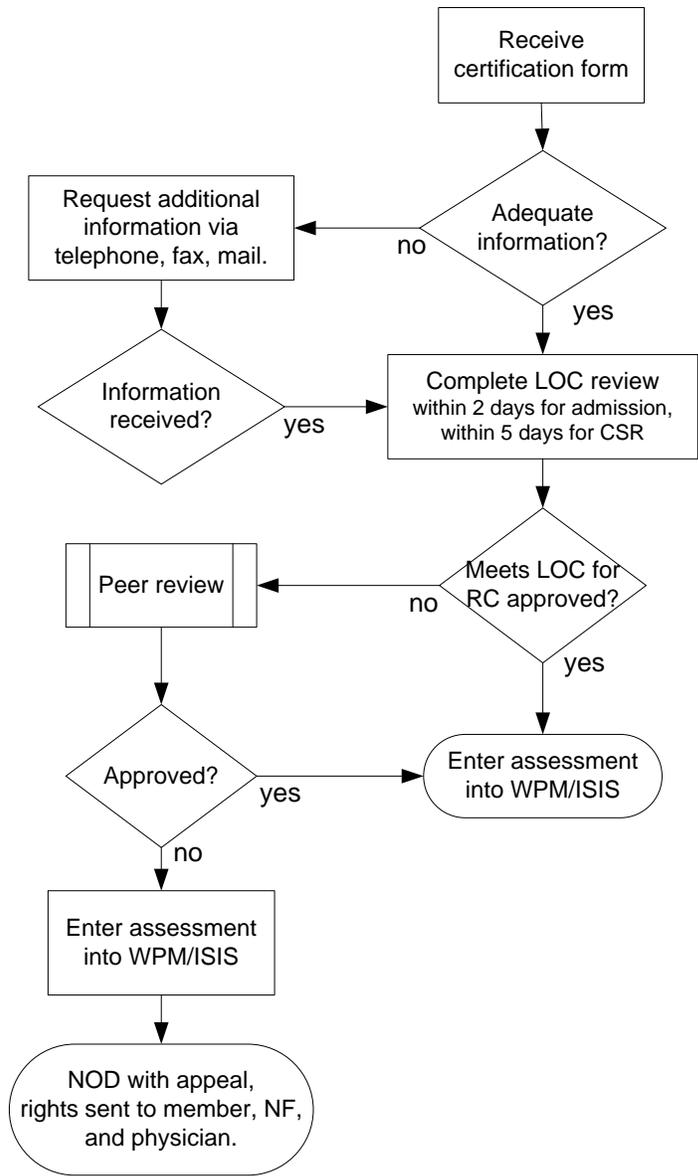
N/A

Interfaces:

N/A

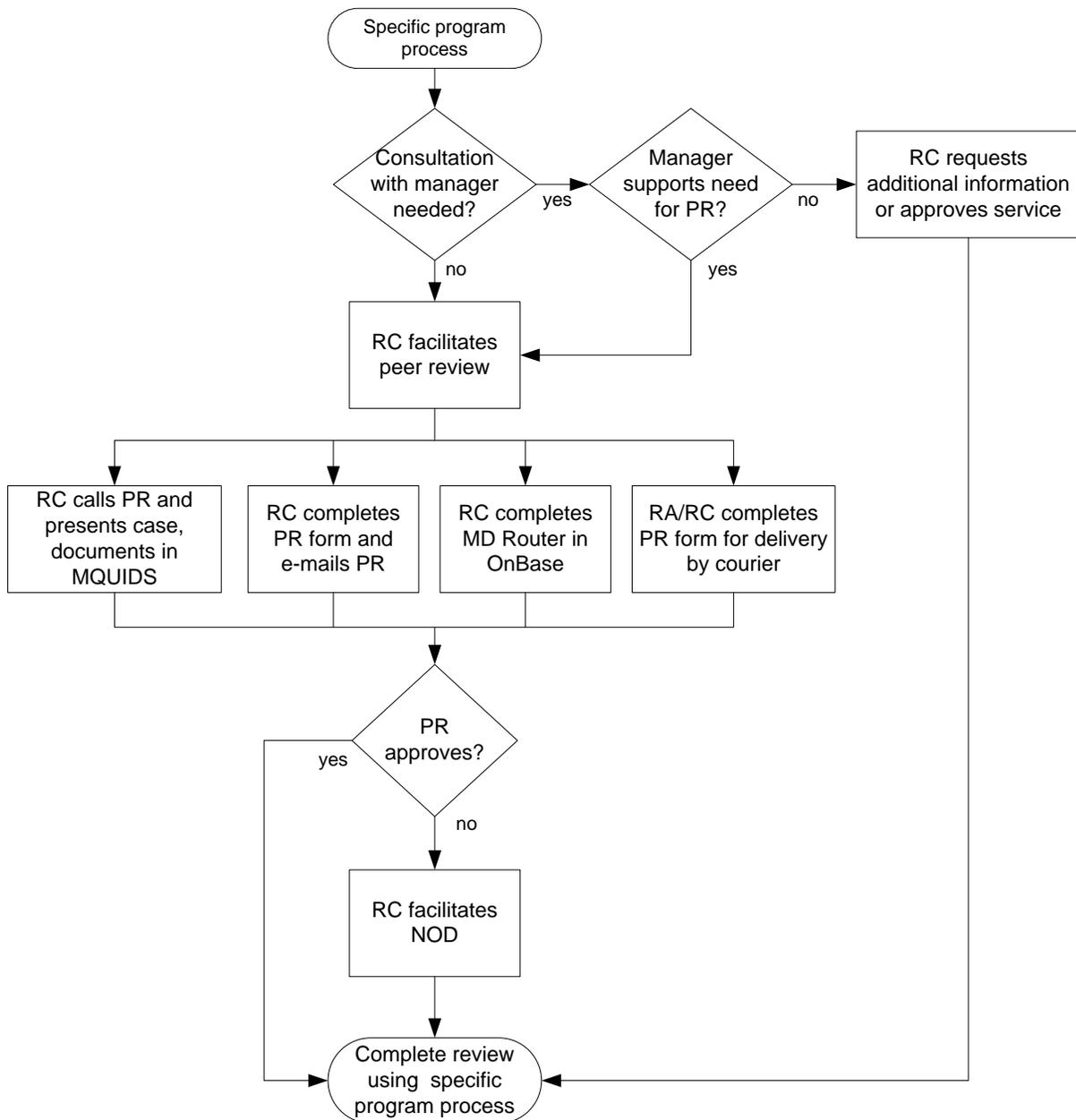
Attachment - A:

Nursing Facility Assessments



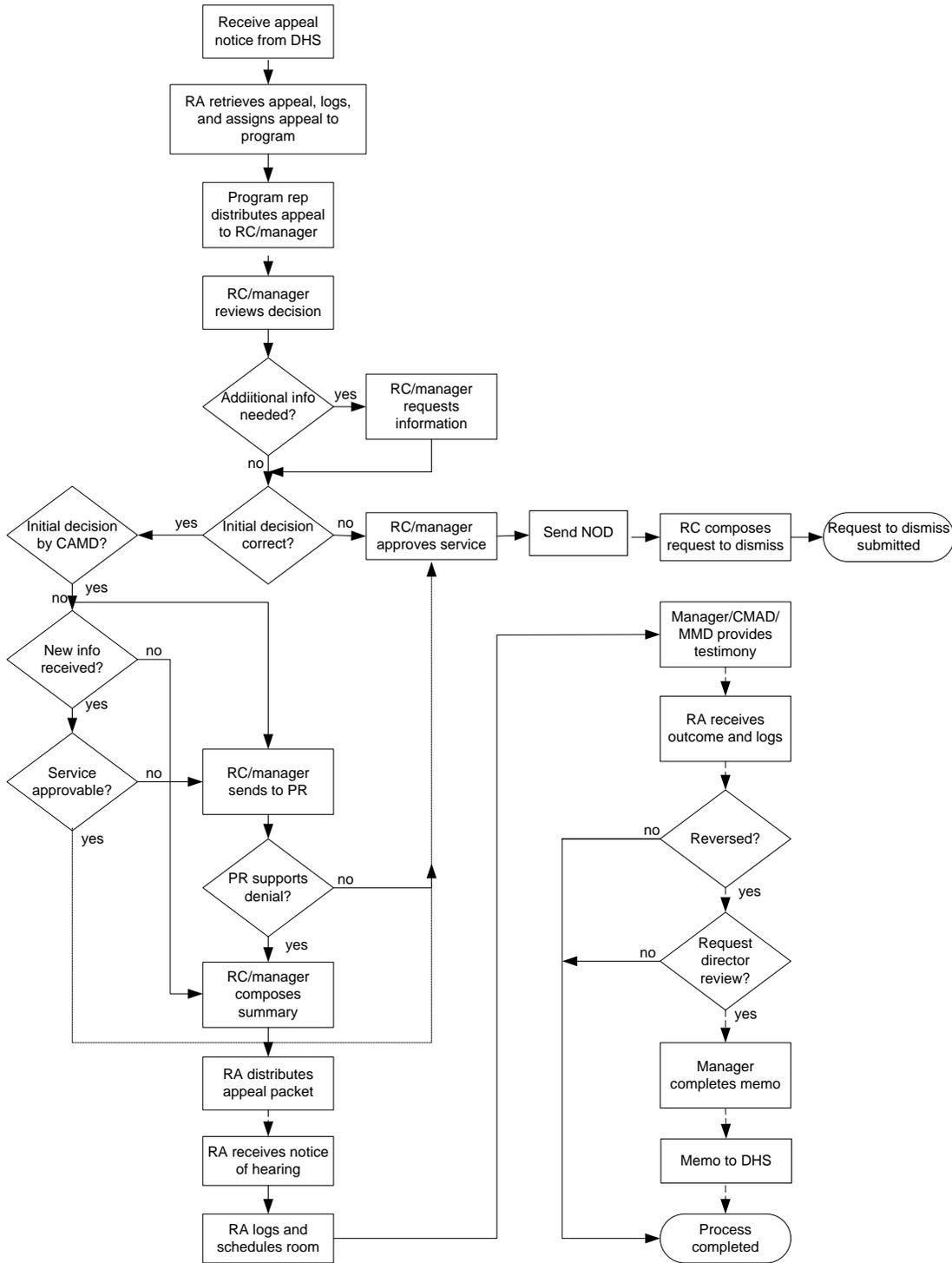
Attachment B:

Peer Review



Attachment C:

ADMINISTRATIVE LAW JUDGE APPEALS



² Iowa Code 135C.1(13); Iowa Administrative Code 441-81.1; Sec. 1919. [42 U.S.C. 1396r]; 42 CFR 440.40