SECTION 14 - SPECIAL DOCUMENTATION REQUIREMENTS

SECTION 14-SPECIAL DOCUMENTATION REQUIREMENTS

14.1 MISSOURI CARE OPTIONS (PRE-LONG-TERM CARE SCREENING (PLTC)

There *must* be a Pre-Long-Term-Care screening (PLTC) screening for all admissions to a MO HealthNet bed for MO HealthNet eligible participants or MO HealthNet applicants. This screening can be as brief as a telephone call or as detailed as a face-to-face interview. A PLTC number *must* be requested from the Department of Health and Senior Services (DHSS), Division of Regulation and Licensure.

14.1.A DA-13

Field #13 in Section A of the DA-124A/B *must* have a valid PLTC number entered there, which can be found on the DA-13. If the resident does *not* have a DA-13 form with that number when he/she is admitted to the facility, the nursing home *must* contact the Central Office Medical Review Unit (COMRU) at the Division of Regulation and Licensure, (573) 526-8609. They give a PLTC number if one has already been assigned or begin the screening process in order to assign a number. The Family Support Division *cannot* authorize nursing home benefits if a screening number has *not* been assigned. If the nursing home admits a resident before a screening has taken place and an exemption is *not* met, the nursing home authorization for payment may be delayed.

14.2 PREADMISSION SCREENING (PASRR)

Section 13 discusses in detail the purpose and process of preadmission screening. Briefly, nursing homes are required to screen all applicants to Title XIX certified beds to determine if the individual is known or suspected to be mentally ill (MI), developmentally disabled (DD), or intellectually disabled (ID). If the applicant is known or suspected to be MI, DD, or ID and no special admissions category applies, he/she *cannot be admitted* to the certified bed until a determination on appropriate placement has been completed by the Department of Mental Health.

A Level I screening *must* be performed on all applicants to a certified bed in order to identify an individual suspected of being MI, DD, or ID. The DA-124C form should be used to do the Level I screening. The form may be completed by a nursing home, hospital or physician.

- If the applicant is *not* known or suspected of being MI, DD, or ID he/she may be admitted to the facility. The DA-124C *must* be filed in the resident's medical records.
- If the applicant is suspected of being MI, DD, or ID form DA-124A/B *must* be completed.

The DA-124A/B and DA-124C *must* be sent to: COMRU, Division of Regulation and Licensure, P.O. Box 570, Jefferson City, MO 65102. *The person cannot be admitted* until a Level II screening is done, unless a special admissions category applies.

If a Level II evaluation is needed, the Notice to the Applicant *must* be given to the individual or his representative.

- An applicant who is inappropriately admitted to a nursing facility according to the PASRR process *cannot* be held liable.

Instructions appear on the back of the form.

14.3 LEVEL OF CARE DETERMINATION

14.3.A DA-124A/B FORM

Eligibility for MO HealthNet nursing home benefits is based on MO HealthNet categorical eligibility, determined by the Family Support Division, and medical eligibility, determined by the Division of Regulation and Licensure. These determinations of eligibility *must* be made before a MO HealthNet nursing home payment can be made on behalf of a participant. A medical consultant in the Division of Regulation and Licensure makes the determination if the applicant for nursing home services needs nursing home level of care. The consultant's determination is based on the established guidelines found in state regulation 19 CSR 30-81.030 and the information given on the DA-124 forms.

The primary responsibility for providing the information on the forms belongs to the physician who signs it. These forms should be completed as fully as possible to allow the state consultant to make a valid determination. The forms may be typed or written legibly in ink.

If providers have any questions concerning how to complete the forms, they may contact the Central Office Medical Review Unit (COMRU) at the Division of Regulation and Licensure, (573) 526-8609. Forms that are *not* completed fully may be returned to the entity that submitted them.

Forms that are completed with insufficient information or are *not* specific enough are returned to the sender. This just delays processing the forms.

14.4 FA-465 FORM

The FA-465 is completed by a Family Support Division caseworker. The original is sent to the participant, or his responsible party, and a copy sent to the nursing home. There are three areas of

information indicated on the form that are most important to the provider in submitting a claim correctly. These are:

- The effective date that the participant is eligible for vendor payments—this date is the earliest date a provider can bill MO HealthNet for services.
- Level of care—this is the level of care that *must* be shown on the claim form.
- Surplus amounts and dates—this is the amount of dollars shown as patient surplus on the claim and the amount of dollars billed to the patient or his responsible party. The date represents the first month that amount is effective.

14.5 PERSONAL FUNDS ACCOUNT BALANCE REPORT

Nursing homes are required to submit a written account of the remaining personal funds for any deceased resident who has received aid, care, assistance or services paid by the Department of Social Services. The resident personal funds account balance *must* be submitted on the Personal Funds Account Balance Report form within 60 days from the date of the resident's death. Providers *must* send this form to the MO HealthNet Division, Cost Recovery/Third Party Liability Unit, PR Recovery, P.O. Box 6500, Jefferson City, MO 65102-6500. The nursing home *must* include on the form the name and address of the resident's estate or the individual designated to receive the resident's quarterly accounting of all financial transactions.

Providers are in violation of MO HealthNet Program regulations under 13 CSR 70-3.030 if, within 60 days of the death of the resident, they fail to submit a complete accounting of the remaining personal funds of a deceased resident who has received aid, care, assistance or services paid by the Department of Social Services. This subject is discussed fully in Section 13.

14.6 EXCEPTION REQUESTS

There are three items/services for which nursing facility providers may request an exception. These are: total parenteral nutrition, rental of ventilators and specialty mattresses.

14.6.A MO HEALTHNET EXCEPTION REQUEST FORM

Emergency requests may be called in by a physician to (800) 392-8030 or (573) 751-3762.

Nonemergency requests may be made by completing the MO HealthNet Exception Request form. This form should be mailed to:

Exception Unit
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500

14.6.B AIR FLUIDIZED/LOW AIR LOSS THERAPY FORM

Requests may be made for specialty mattresses and bed rentals related to low-air loss flotation mattresses and air-fluidized beds. These requests should always be made in writing. In addition to completing the MO HealthNet Exception Request form, providers *must* complete the Air Fluidized/Low Air Loss Therapy flow sheet. Mail both forms to the address given above.

Exception requests are discussed fully in Section 20 of this manual. Section 20 also contains a sample of the MO HealthNet Exception Request. All MO HealthNet Exception Request forms *must* be initiated by the physician. A nursing facility *cannot* initiate the request.

14.7 REPORTING REQUIREMENT FOR ACCIDENTAL INJURIES

Missouri statute 208.215 requires that MO HealthNet participants report injuries to the MO HealthNet Division (MHD) within thirty (30) days of occurrence. For those MO HealthNet participants residing in Nursing Facilities, the MO HealthNet Accident Report (TPL-2P) should be completed by authorized facility personnel to report injuries sustained by the participant while under the care of the facility.

Exception—Minor injuries should *not* be reported. To do so involves unnecessary facility staff time and MHD time. As a guideline, a report is requested for any injury in which a medical professional, doctor or nurse is consulted, either staff or outside, or x-ray services are required *AND* the injury requires specialized care for a period of time. ***Example:*** a fall out of bed. Bruises, it is assumed, are looked at by a staff nurse. However, specialized care is *not* expected. If the fall involved a broken bone, dislocation, concussion or similar injury, it is anticipated that specialized care is necessary.

Nursing home personnel *must* complete the TPL-2P with details concerning the accident and submit the form to the following address:

Cost Recovery/Third Party Liability Unit
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500

A copy of the TPL-2P form should be filed in the patient's case record.

TPL-2P forms may be obtained by requesting them on the Forms Request.

In the billing and/or payment process, if a claim is processed in which the nursing facility has indicated a trauma diagnosis code, and no TPL-2P has been received by the Cost Recovery/Third Party Liability Unit, the system generates a TPL-2P to the participant requesting further information.

The participant or payee or guardian should sign on the blank line at bottom right-hand corner of the TPL-2P and enter date the form was signed. If the signature is *not* available at the time the form is completed, the facility personnel who completed the form should sign and date the form, and give the reason the claimant's signature was unavailable. Reference Section 5 for complete information on the TPL-2P.

END OF SECTION

TOP OF PAGE