10-144

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chapter 101

MAINECARE BENEFITS MANUAL

Chapter II

Section 67

NURSING FACILITY SERVICES

Note: Language in this policy that relates to assessment practices for person with Alzheimer's disease and other dementia have been deemed major substantive rules per Public Law 1995, Chapter 687 and Title 22 §3174-I.

SECTION 67 NURSING FACILITY SERVICES ESTABLISHED 7/1/91

LAST UPDATED 4/25/10

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SECTION 67 **NURSING FACILITY SERVICES** **ESTABLISHED 7/1/91**
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67.01 **DEFINITIONS**

67.01-1 **Nursing Facility** (NF) means, a Skilled Nursing Facility (SNF) in the Medicare program or a Nursing Facility (NF) in the MaineCare program which meets State licensing and Federal certification requirements for nursing facilities and has a valid agreement with the Department of Health and Human Services (**the Department**).

"Nursing facility" may include a distinct part of an institution which meets the above requirements.

A NF may not be an institution for mental diseases, nor an institution for the mentally retarded or persons with related conditions.

67.01-2 **Nursing Facility Services** means services that are:

- primarily professional nursing care or rehabilitative services for injured, disabled, or sick persons;
- needed on a daily basis and as a practical matter can only be provided in a nursing facility;
- ordered by and provided under the direction of a physician; and
- less intensive than hospital inpatient services.

67.01-3 **Dually-Certified Facility** is a facility that is certified to participate in both the Medicare and MaineCare programs. Dually-certified facilities are not limited to distinct parts since all of the beds in the facility are dually-certified.

67.01-4 **Swing-Bed** is a skilled Medicare certified hospital bed that may be used interchangeably as an acute care bed or a skilled nursing facility bed. For additional information pertaining to swing-beds refer to Chapter II, Section 45, of this Manual regarding Hospital Services.

67.01-5 **Utilization Review** is the evaluation of the necessity, appropriateness, and efficiency of the use of services, procedures, and facilities by each participating nursing facility. It includes a review of the appropriateness of admissions, services ordered and provided, continued stays, and discharge practices.

67.01-6 **Mental Illness** (MI) or a mental disorder is: (a) schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder;

67.01 **DEFINITIONS** (cont.)

personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but (b) not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in Section 67.01-6(a).

67.01-7 **Mental Retardation** (MR) means a condition of an individual as defined in the most current version of the American Psychiatric Association's Diagnostic and Statistical Manual.

67.01-8 **Resident Assessment Instrument** (RAI) is the assessment tool approved by the Department to provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. It is comprised of the Minimum Data Set (MDS) and the Resident Assessment Protocols (RAPs). The RAI is not an assessment tool for determination of medical eligibility.

67.01-9 **Plan of Care** (or care plan) includes measurable objectives and timetables related to meeting a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident assessment. The care plan must describe the following: 1) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and 2) Any services that would otherwise be required but are not provided due to the resident's exercise of his or her rights, including the right to refuse treatment. A copy of the Plan of Care is included in the member’s medical record.

67.01-10 **Limited Assistance** is a term used to describe an individual's self-care performance in activities of daily living, as defined by the Minimum Data Set (MDS) assessment process. It means although the individual was highly involved in the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:

- Guided maneuvering of limbs or other non-weight-bearing assistance three (3) or more times, or

- Limited assistance (three (3) or more times,) **plus** weight-bearing support provided only one (1) or two (2) times.

67.01-11 **One-person Physical Assist** requires one (1) person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting. This does not include cueing.

67.01 **DEFINITIONS** (cont.)

67.01-12 **Extensive Assistance** means although the individual performed part of the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:

- Weight-bearing support three (3) or more times, or
- Full staff performance during part (but not all) of the last seven (7) days.

67.01-13 **Total Dependence** means full staff performance of the activity during the entire last seven (7) day period across all shifts. Complete non-participation by the resident in all aspects of the Activities of Daily Living (ADLs).

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67.01-14 **Specialized Services for People with Mental Retardation or Other Related Conditions** are continuous active treatment programs that include aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services.

67.01-15 **Specialized Services for People with Mental Illness** are mental health services developed by an interdisciplinary team and include specific therapies and activities that are directed at diagnosing conditions, reducing symptoms, and achieving a level of functioning that permits reduction in the intensity of mental health services.

67.01-16 **Unstable**: A medical condition is unstable when it is fluctuating in an irregular way and/or is deteriorating and affects the resident's ability o function independently. These changes must require medical treatment and professional nursing observation assessment and management at least once every eight (8) hours. The change or decline in physical health requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. The loss of function resulting from a temporary disability from which full recovery is expected does not qualify as instability as defined under this Section.

67.01-17 **Assessment Form**: The form approved by the Department for medical eligibility determination or advisory assessments required in this Section. The definitions, scoring mechanisms and time-frames included in this form are outlined in Section 67.02-3. This form is also known as the Medical Eligibility Determination (MED) form. The Assessment Form does not include the Minimum Data Set (MDS).

67.01 **DEFINITIONS** (cont.)

67.01-18 **Residence**: means an individual's permanent dwelling. If the individual does not have a permanent dwelling, the nursing facility shall be considered his/her residence.

67.01-19 **Cognition** is the ability to recall what is learned or known and the ability to make decisions regarding tasks of daily life. Cognition is evaluated in terms of:

1. Memory: short-term and long-term memory;

2. Memory/recall ability during last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital; and

3. Cognitive skills for daily decision making on a scale including: independent; modified independence; moderately impaired; severely impaired.

A "threshold" score for "cognition" on the eligibility Assessment Form is equal to a score of one (1) for loss of short term memory and one (1) or two (2) of items A-D or E, no items for memory/recall ability, and a score of two (2) or three (3) for cognitive skills for decision making.

67.01-20 **Problem Behavior** refers to wandering with no rational purpose; verbal abuse; or physical abuse; or socially inappropriate/disruptive behavior. A "threshold" score for problem behavior on the eligibility Assessment Form is equal to a score of two (2) or three (3) in one (1) of these four (4) criteria and occurs at least four (4) days per week.

67.01-21 **Authorized Agent** shall mean the organization authorized by the Department to perform specified functions pursuant to a signed contract or other approved signed agreement.

67.01-22 **Brain Injury (BI)** is an insult to the brain resulting directly or indirectly from trauma, infection, anoxia, or vascular lesions, and not of a degenerative or congenital nature, but which may produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities and/or physical or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment.

67.01-23 **Frequent Change in Care Setting** shall mean three (3) or more moves from one care setting to another care setting, including the following settings: home, residential care facility, nursing facility or other specialized facility, excluding hospitals, within a nine (9) month period. Hospital admissions/discharges are not counted as a change in care setting or move. Each change in care setting counts as one (1) move, e.g. - moving from home

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67.01 **DEFINITIONS** (cont.)

to NF counts as one (1) move; - moving from home to NF and back home counts as two (2) moves. (A change in the "level of care" within a facility is not a "change in care setting" under this Section.)

67.01-24 **Member** in this Section is an individual who meets financial and other eligibility requirements set forth in the MaineCare Eligibility Manual and has also been determined to meet the eligibility requirements of this Section and is prior authorized to receive services. For purposes of making health care decisions, a member may be represented by his or her "guardian," "agent" or "surrogate," as these terms are defined in 18-A MRSA Sec. 5-801.

67.01-25 **Significant Change** means a major change in the member's status that is not self-limiting, impacts on more than one (1) area of functional or health status, and requires multi-disciplinary review or revision of the authorized plan of care. A significant change assessment is appropriate if there is a consistent pattern of change with either two (2) or more areas of improvement, two (2) or more areas of decline, or would impact the member's NF level of care.

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67.01-26 **Rehabilitation Potential** is the documented expectation by a physician of measurable, "functionally significant improvement" (the demonstrable, measurable increase in the individual's ability to perform specific tasks or motions that contribute to independence outside the therapeutic environment) in the individual's condition in a reasonable, predictable period of time as the result of the prescribed treatment plan. The physician documentation of rehabilitation potential must include the reasons used to support the physician expectation and must follow guidelines detailed in MaineCare Benefits Manual (MBM), Chapter II, Section 90, Physician Services.

Effective 4/1/10

67.01-27 **Other Related Conditions(ORC)** means (i) cerebral palsy or epilepsy or (ii) any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for those persons. Further, the condition must manifest before the person reaches age 22 years, be likely to continue indefinitely, and result in functional limitations in three (3) or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

67.02 **ELIGIBILITY FOR CARE**

67.02-1 **General and Specific Requirements**

Effective 4/25/10

MaineCare coverage of NF services requires prior approval from the Department or its Authorized Agent. NF services are covered for an approved eligibility period for each MaineCare member. Beginning and end dates of the individual's eligibility period correspond to beginning and end dates for MaineCare reimbursement. MaineCare coverage shall end on the eligibility end date unless a new eligibility period has been authorized. A person is

67.02 **ELIGIBILITY FOR CARE** (cont.)

eligible to receive covered services if he or she meets: general MaineCare financial eligibility requirements and other eligibility requirements set forth in the MaineCare Eligibility Manual, medical eligibility requirements, as set forth in Section 67.02-3 and as documented on the MED form completed by the Department or its Authorized Agent, and other specific requirements for NF services.

67.02-2 **General Requirements**. A person must meet the MaineCare financial eligibility requirements and other eligibility requirements set forth in the MaineCare Eligibility Manual, as determined by the Office of Integrated Access and Support.

67.02-3 **Medical Requirements**

Effective 4/25/10

In order to receive services under this Section applicants must meet the eligibility requirements as set forth in this Section and as documented on the MED form. An applicant for services or a resident under this Section meets the medical eligibility requirements for admission to a nursing facility if he or she requires the services specified in 67.02-3(A) OR (B) OR (C), as determined or otherwise verified by the Department or its Authorized Agent and documented on the approved MED form. The timeframes used to determine medical eligibility are incorporated in the MED form. If an applicant or member is placed in a NF facility out of state, then the MED form that is completed by the Department or its Authorized Agent must be submitted as part of the out of state prior authorization process that is described in Chapter I, Section 1.14-2 of the MBM.

A. A person meets the medical eligibility requirements for NF services if he or she needs at least one (1) of the following services seven (7) days per week (unless otherwise specified) that are or otherwise would be performed by or under the supervision of a registered professional nurse:

1. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, all for treatment of unstable conditions requiring medical or nursing intervention. Daily insulin injections for an individual whose diabetes is under control do not meet the requirements of this Section;

2. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past thirty (30) days) or unstable condition;

3. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent or unstable condition;

4. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or

67.02 **ELIGIBILITY FOR CARE** (cont.)

sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, second or third degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);

5. administration of oxygen on a regular and continuing basis when the person's medical condition warrants professional nursing observation, for a new or recent (within past thirty (30) days) condition;

6. professional nursing assessment, observation and management of an unstable medical condition (observation must, however, be needed at least once per shift throughout the twenty-four (24) hours);

7. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care.

   In such instances, the need for a catheter must be documented and justified in the person's medical record;

8 physical, speech/language, occupational, or respiratory therapy provided at least five (5) days per week as part of a planned program that is designed, established by, and provided by, and requires the professional skills of, a licensed or registered therapist. (Therapy services may be delivered by a qualified licensed or certified therapy assistant under the direction of a qualified professional therapist.) The findings of an initial evaluation and periodic reassessments must be documented in the person's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame. With the exception of speech/language criteria outlined under 67.05-13 (E), maintenance or preventative therapy does not meet the requirements of this Section. A Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BIPAP) system or the wearing of an airway clearance system vest does not meet the requirements of this Section;

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9. services to manage a comatose condition;

10. care to manage conditions requiring a ventilator/ respirator at least three (3) days per week;

67.02 **ELIGIBILITY FOR CARE** (cont.)

11. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e.: grandmal) at least weekly; or

12. extensive assistance or total dependence with three (3) of the following five (5) activities of daily living: a) bed mobility; (b) transfer; (c) locomotion; (d) eating; and (e) toilet use (refer to 67.02-3(B)(2) below).

B. A person meets the medical eligibility requirements for NF services if he or she needs a combination of at least three (3) of the following services described in 67.02-3(B) below, including at least one (1) of the nursing services described in 67.02-3(B)(1), that are or otherwise would be performed by or under the supervision of a registered professional nurse.

1. **Nursing Services**

Nursing services include any of the following on a frequent basis of a minimum of three (3) days a week unless otherwise specified:

a. any physician-ordered services specified in 67.02-3(A) but provided on a frequent rather than daily basis;

b. professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;

i. If an individual meets the threshold for deficits in cognition as defined in Sec. 67.01-19, but otherwise does not require professional nursing intervention at least three (3) days per week, then the individual shall be assessed in accordance with Section 67.02-3 (C) below.

c. professional nursing assessment, observation, and management for problems including wandering, physical abuse, verbal abuse or socially inappropriate behavior;

i. If an individual meets the threshold for deficits in behavior as defined in Section 67.01-20, but otherwise does not require professional nursing intervention at least three (3) days per week, then the individual shall be assessed in accordance with Section 67.02-3 (C) below.

67.02 **ELIGIBILITY FOR CARE** (cont.)

d. physician-ordered occupational, physical, or speech-language therapy provided at least three (3) days a week as part of a planned program that is designed by, established by, provided by, and requires the professional skills of, a licensed or registered therapist. (Therapy services may be delivered by a qualified licensed or certified therapy assistant, under the direction of a qualified professional therapist.) The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Therapeutic services must be ordered by a physician for individuals twenty-one (21) years of age or older.

Rehabilitation potential (see Section 67.01-26) must be documented by the physician for these speech-language services for individuals twenty-one (21) years of age or older.

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With the exception of speech/language criteria outlined under 67.05-13 (E), maintenance or preventative services do not meet the requirements of this Section.

e. administration of treatments (excluding: nebulizers, CPAP or BIPAP systems, and airway clearance system vest), procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring; or

f. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.

2. **Activities of Daily Living**

At least "limited assistance" (defined in 67.01) and a "one person physical assist" (defined in 67.01) is needed with the following activities of daily living:

a. **Bed Mobility**: how person moves to and from lying position, turns side to side, and positions body while in bed;

b. **Transfer:** how person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet and dressing);

c. **Locomotion:** how person moves between locations on the same floor, in room and other areas. If in wheelchair, self-sufficiency once in chair;

67.02 **ELIGIBILITY FOR CARE** (cont.)

d. **Eating**: how person eats and drinks (regardless of skill); and

e. **Toilet Use**: how person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

C. An individual who meets the threshold for deficits in criteria 67.02-3 (B)(1)(b) cognition and/or (B)(1)(c) behavior, as defined in Section 67.01-19 and 67.01-20 respectively, but otherwise does not require professional nursing intervention at least three (3) days per week, then the individual shall be assessed using the criteria below. The individual shall be eligible for NF services if he or she has a qualifying score on the Cognitive Screen and/or Behavioral Screen, in combination with a need for at least "limited assistance" with an activity(ies) of daily living described in Section (B)(2), for a total of three (3) service needs. (e.g. Cognitive score =thirteen (13) points and two (2) ADL's; OR Cognitive score = thirteen (13) points and Behavioral score = fourteen (14) points and one (1) ADL; OR Behavioral score = fourteen (14) points and two (2) ADL's)

1. **Cognition Screen** Sixteen (16) points available, thirteen (13) required

a. Memory for Events:

0 Can recall details and sequences of recent experiences and remember names of meaningful acquaintances.
1 Cannot recall details or sequences of recent events or remember names of meaningful acquaintances.
2 Cannot recall entire event or names of close friends or relatives (e.g., recent outings, visits of relatives or friends) without prompting.
3 Cannot recall entire event or name of spouse or other living partner even with prompting.

b. Memory and Use of Information:

0 Does not have difficulty remembering and using information. Does not require directions or reminding from others.
1 Has minimal difficulty remembering and using information. Requires direction and reminding from others one (1) to three (3) times per day. Can follow written instructions.
2 Has difficulty remembering and using information. Requires direction and reminding from others four

67.02 **ELIGIBILITY FOR CARE** (cont.)

(4) or more times per day. Cannot follow written instructions.
4 Cannot remember or use information. Requires continual verbal reminding.

c. Global Confusion:

0 Appropriately responsive to environment.
1 Nocturnal confusion on awaking.
2 Periodic confusion during daytime.
3 Nearly always confused.

d. Spatial Orientation:

0 Oriented, able to find and keep his/her bearings.
1 Spatial confusion when driving or riding in local community.
2 Gets lost when walking in neighborhood.
3 Gets lost in own home or present environment.

e. Verbal Communication:

0 Speaks normally.
1 Minor difficulty with speech or word-finding difficulties.
2 Able to carry out only simple, uncomplicated conversations.
3 Unable to speak coherently or make needs known.

2. **Behavior Screen** Twenty (20) points available, fourteen (14) required

a. Sleep Patterns:

0 Unchanged from “normal” for the individual.
1 Sleeps, noticeably more or less “normal”.
2 Restless, nightmares, disturbed sleep, increased awakenings.
4 Up wandering for all or most of the night, inability to sleep.

b. Wandering:

0 Does not wander.
1 Does not wander. Is chair bound or bed bound.
2 Wanders within the facility or residence and may wander outside, but does not jeopardize health and safety.

67.02 **ELIGIBILITY FOR CARE** (cont.)

3 Wanders within the facility or residence. May wander outside; health and safety may be jeopardized. Does not have history of getting lost and is not combative about returning.

4 Wanders outside and leaves grounds. Has a consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the use of psychotropic drugs for management and safety.

c. Behavioral Demands on Others:

0 Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions.

1 Attitudes, habits and emotional states limit the individual's type of living arrangement and companions.

3 Attitudes, disturbances and emotional states create consistent difficulties that are modifiable to manageable levels. The individual's behavior can be changed to reach the desired outcome through respite, in-home services, or existing facility staffing.

4 Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels. The individual's behavior cannot be changed to reach the desired outcome through respite, in-home services, or existing facility staffing, even with training for the caregiver.

d. Danger to Self and Others:

0 Is not disruptive or aggressive, and is not dangerous.

1 Is not capable of harming self or others because of mobility limitations (is bed bound or chair bound).

2 Is sometimes (one (1) to three (3) times in the last seven (7) days) disruptive or aggressive, either physically or verbally, or is frequently extremely agitated or anxious, even after proper evaluation and treatment.

3 Is frequently (four (4) or more times during the last seven (7) days) disruptive or aggressive, or is frequently extremely agitated or anxious, and professional judgment is required to determine when to administer prescribed medication.

5 Is dangerous or physically abusive, and even with proper evaluation and treatment, may require physician's orders for appropriate interventions.

67.02 **ELIGIBILITY FOR CARE** (cont.)

e. Awareness of Needs/Judgment:

0 Understands those needs that must be met to maintain self care.
1 Sometimes (one (1) to three (3) times in the last seven (7) days) has difficulty understanding those needs that must be met, but will cooperate when given direction or explanation.
2 Frequently (four (4) or more times during the last seven (7) days) has difficulty understanding those needs that must be met, but will cooperate when given direction or explanation.
3 Does not understand those needs that must be met for self care and will not cooperate even though given direction or explanation.

67.02-4 **Other Specific Requirements**

Nursing facility services are covered under the MaineCare program if an applicant is determined to be medically eligible, according to 67.02-3(A) OR (B) OR (C), and when all of the following conditions are met:

A. An applicant who meets the NF medical eligibility criteria in 67.02-3 has been informed of, and offered the choice of, available, appropriate, and cost-effective home and community-based services and alternatives to NF placement. The relative costs to the applicant of each option must be explained.

B. The Assessment Form and the preadmission screening (PASARR) for mental illness and mental retardation have been completed, or the applicant is otherwise exempt (see Section 67.05-1).

C. The applicant (or applicant's guardian, or applicant's agent or surrogate, as defined in 18-A MRSA Sec. 5-801 and evidenced by a valid, signed document on file at the NF, available upon request) selected placement in the nursing facility as documented by a signed choice letter.

D. The nursing facility to be reimbursed has the signed orders for NF services by the physician responsible for the care of the resident. The medical care of each resident must be supervised by a physician.

E. No Medicare or other third-party payment is available for the services, in accordance with Chapter I, MaineCare Benefits Manual.

67.02 **ELIGIBILITY FOR CARE** (cont.)

67.02-5 **Medical Requirements for Brain Injury (BI) Services**

A person meets the medical eligibility requirements for NF BI services if he or she has been determined to meet the NF eligibility requirements of Sections 67.02-3 and 67.02-4 AND meets the following BI criteria as determined or otherwise verified by the Department or its Authorized Agent.

A. The individual has sustained a brain injury as defined in Section 67.01-22; and

B. The individual has been assessed by the Disability Rating Scale(DRS) (See Appendix 1) administered by the Department or its Authorized Agent, and has received a score between seven (7) and twenty-one (21) inclusive; and

C. The individual has received an assessment by a qualified neuropsychologist (as defined in the MBM, Rehabilitative Services, Section 102.08-5 B) and/or a licensed physician who is Board certified, or otherwise Board eligible in Physical Medicine and Rehabilitation. The assessment must at least:

1. positively indicate the individual: is not in a persistent vegetative state, is able to demonstrate potential for physical and/or behavioral and/or cognitive rehabilitation; and shows evidence of moderate to severe behavioral and/or cognitive and/or functional disabilities; and

2. result in specific rehabilitation goals, based upon the findings of the assessment, describing types and frequencies of therapies and expected outcomes and timeframes.

In order for services to be covered under the BI rate of reimbursement, the assessment as described in 67.02-5(C) must be completed and a rehabilitation plan of care based upon the findings of the assessment must be in place. An assessment conducted up to no more than three (3) months prior to admission will be accepted. If the individual meets the requirements of Section 67.02-3 and 67.02-4, he or she may be classified and reimbursed for NF level of care. The individual will be classified NF-BI when the additional requirements of Section 67.02-5 are met.

67.02-6 **Extraordinary Circumstances (EC)**

A. A nursing facility must request and receive written approval for a member's continued stay under "extraordinary circumstances." (Please refer to 67.05-4.). A NF MaineCare member whose length of stay has been reimbursed by MaineCare for more than one hundred-twenty (120) consecutive days may continue to stay in the NF due to "extraordinary circumstances" if it has been determined after documented discharge planning that:

67.02 **ELIGIBILITY FOR CARE** (cont.)

1. There is no available, appropriate placement within a sixty (60) mile radius of the member's residence; AND

2. Discharge from the NF would pose serious risk to the individual's health, welfare, or safety.

The counting of one hundred-twenty (120) consecutive days may include short-term hospital stays (ten (10) or fewer days), but may not

include any days accrued during an appeal process, which begins on the day the member requests an appeal with the Department (see Section 67.05-18).

B. MaineCare coverage for "extraordinary circumstances" shall be for a specified period approved by the Department. For coverage to continue beyond the approved period, the NF must submit a completed request form to the Department at least five (5) calendar days prior to the end date of the member's approved EC period. If appropriate, the Department will approve a new EC certification period. When a member is admitted to a hospital, the EC period ends on the date of admission. A member must be assessed by the Department or its Authorized Agent prior to the member's return to the NF as required under Section 67.05-2(B).

67.02-7 **Frequent Change in Care Settings**

A. In order to promote the health and well-being of a member who has experienced frequent changes in health status, resulting in frequent changes in care settings (defined in 67.01-23), coverage for NF services may continue even though the member's health status has improved such that he or she no longer meets the Section 67.02-3 medical eligibility requirements for NF level care, and would otherwise be discharged, if the following additional criteria are met:

1. The member has lost medical eligibility for NF services at least twice, while receiving covered services in the NF, during the past nine (9) month period; and

2. The member has a chronic or unstable medical condition that would likely result in re-admission to the NF within three (3) months of discharge; and

3. The various settings (including home), within the last nine (9) months, must be listed, each facility identified with admission and discharge dates documented; and

4. The member (or member's guardian, or member's agent or surrogate, as defined in 18-A MRSA Sec. 5-801 and evidenced

67.02 **ELIGIBILITY FOR CARE** (cont.)

by a valid, signed document on file at the NF, available upon request) chooses to continue to stay in the NF, as documented by a signed Choice Letter.

B. The member will be determined eligible pursuant to the requirements of this Section by the Department. The NF shall submit the above required information to the Department with a request for classification under this Section. If approved, a classification period will be established. The member must be reassessed within five (5) calendar days prior to the end date of the member's approved classification period, if an additional classification period is requested under this Section. The Department shall consider the member's recent history of frequent changes in care settings, as well as health status, and may continue to classify him/her for NF coverage under this Section as appropriate.

67.02-8 **Significant Change Assessment**

A. If the NF believes the member has become medically eligible for NF services during a certified EC period, during an appeal or while awaiting placement for residential care, then the NF shall request a significant change eligibility assessment from the Department or its Authorized Agent. A significant change (see Section 67.01-25) MDS assessment and the most recent quarterly MDS assessment, prior to this change, must be submitted to the Department or its Authorized Agent. In order for the Department or its Authorized Agent to complete an Assessment Form, the significant change areas must impact on this Section's eligibility.

B. The significant change assessment process applies to current residents, whom the facility believes meet the medical eligibility criteria and are under appeal for denial of medical eligibility or have within the past year had an Assessment Form appealed and upheld as accurate by the Commissioner's final ruling in the appeal. It also applies to members receiving extraordinary circumstances or frequent change eligibility as exceptions to medical eligibility.

Effective 4/19/10

67.02-9 **Days Awaiting Placement for Residential Care Facility**

Current nursing facility residents who have no federal third party coverage or long term care insurance coverage and who have been determined not medically eligible for MaineCare nursing facility benefits may continue to stay in the nursing facility subject to all of the following conditions:

A. The resident has received notice that he/she is not medically eligible for NF MaineCare benefits, the facility has initiated the discharge process, and has determined that there is no safe and appropriate placement currently available.

67.02 **ELIGIBILITY FOR CARE** (cont.)

Effective 4/25/10

B. The individual meets the medical and financial eligibility requirements for MaineCare coverage in a cost reimbursed residential care facility, as determined by the regional Office of Integrated Access and Support.

C. The member met the MaineCare medical eligibility criteria for NF in effect at the time of admission to the nursing facility.

D. The nursing facility continually pursues discharge of the member. The nursing facility shall continue to document in the member's record all efforts to locate appropriate placement.

E. The member accepts the first available, appropriate placement within a sixty (60) mile radius of the facility or the member's home, if applicable. The member may accept a placement beyond the sixty (60) mile radius. However, this is not required. The nursing facility must notify the Department if a member refuses a placement meeting these criteria. If the member refuses this placement, the Department will issue a thirty (30) day notice to the nursing facility that reimbursement will terminate.

67.03 **DURATION OF CARE**

Effective 4/19/10

Eligible Title XIX and XXI members are entitled to receive as many days of NF services as are medically necessary as long as the member meets the eligibility for care requirements set forth under Section 67.02, or otherwise meets the exception specified under 67.05-1 (G). MaineCare coverage of NF services requires prior approval from the Department or its Authorized Agent. Beginning and end dates of an individual's eligibility period corresponds to the beginning and end dates for MaineCare reimbursement. The Department, or its Authorized Agent may grant eligibility for NF services on a short or long term basis, based upon the complexity, frequency and length of time that services are needed.

The Department, or its Authorized Agent may, at any time, review an individual's need for NF services.

67.04 **STANDARDS OF CARE**

All nursing facilities must meet the following standards to qualify for MaineCare reimbursement:

67.04-1 **General Regulatory Compliance**

A. In order to qualify for reimbursement under this Section, NFs, including those operated by the State of Maine, must meet the requirements contained in the Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities as are currently in effect. NFs must also comply with the Principles of Reimbursement for Nursing Facilities; and all requirements of Title XIX of the Social Security Act and the CFR, Subpart B, Requirements for Long Term Care Facilities, 42 CFR 483 issued pursuant thereto, as are most currently in effect. These standards are incorporated into this Section by reference as if set out fully herein.

67.04 **STANDARDS OF CARE** (cont.)

B. All NFs including those operated by the State of Maine, must obtain a license from the Department of Health and Human Services in order to qualify for Title XIX reimbursement. However, the license shall not be considered valid evidence that the facility meets all requirements for certification under MaineCare regulations if the Secretary of Health and Human Services has established, on the basis of an on-site monitoring survey or other federal review, that the Department's certification agency has failed to properly apply Federal certification standards or procedures.

C. Each NF must obtain Medicare certification for a minimum of twenty percent (20%) of its licensed bed capacity. Additionally, any NF that participates in the MaineCare program must follow required Federal procedures for certification and become certified following the Department's recommendation for certification; submit an annual application for Medicare participation at the same time applications for licenses and MaineCare certification are due; and participate in the Medicare program by billing Medicare for care provided to eligible members prior to billing MaineCare.

D. Sanctions. Failure to comply with any of the provisions in Section 67.04-1(C) may result in the imposition of a penalty of one hundred dollars ($100) per bed. This penalty must be imposed for each day a NF fails to comply with the requirement that the NF participate in the Medicare program by billing Medicare for care provided to eligible members prior to billing MaineCare. A repeated failure to comply with any provision in Section 67.04-1(C) will result in fines of two hundred dollars ($200) per bed. The imposition and collection of these sanctions are governed by 22 M.R.S.A. §7946.

E. In order to qualify for reimbursement for laboratory services by nursing facilities, those laboratory services must be in compliance with the rules implementing the Clinical Laboratory Improvement Amendments (CLIA) of 1988, and any amendments thereto, or otherwise have a waiver. CLIA regulations are located at following website: http://www.phppo.cdc.gov/clia/regs/toc.aspx

67.04-2 **Training Requirements for Alzheimer's and Dementia Services**

Nursing facilities that admit members or have members determined eligible based in part on the supplemental dementia screen in Section 67.02-3 (C) will be reimbursed with MaineCare funds for those members if the NF can document that it meets the following training standards:

67.04 **STANDARDS OF CARE** (cont.)

A. The NF must document six (6) hours of classroom training on Alzheimer's and other dementia for all licensed staff, CNA, social work, activities and housekeeping staff. In addition, the NF must be able to document six (6) hours of clinical experience for licensed staff, CNA, social work and activities staff. In addition, four (4) of the twelve (12) contact hours required for CNA certification in-service must be in the area of managing residents with cognitive impairments.

B. Training shall be provided by individuals qualified by education or experience and must include, but is not limited to the following topics:

- diseases and conditions that cause dementia;
- behavior management;
- communication with resident and family;
- creating a therapeutic environment;
- promoting functional independence;
- legal and ethical issues; and
- mandatory reporting of abuse, neglect and exploitation.

67.05 **POLICIES AND PROCEDURES**

All nursing facilities must establish and maintain policies and practices regarding transfer, discharge, and the provision of services that are the same for all individuals regardless of source of payment.

67.05-1 **Preadmission Screening (PAS) and Change In Condition (CIC) Reviews for Mental Illness and Mental Retardation**

A. Nursing facilities must not admit any new resident who has:

Mental Illness (MI), unless the State mental health authority, has determined, based on an independent evaluation performed by a person or entity other than the Department, prior to admission, that the individual requires the level of services provided by a NF and, if so, whether the individual requires specialized services for MI; or

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Mental Retardation (MR) or other related conditions (ORC), unless the State mental retardation authority has determined prior to admission that the individual requires the level of services provided by a NF, and, if so, whether the individual requires specialized services for MR or ORC. Determinations made by the State mental health or mental retardation authorities (Office of Adult Mental Health Services and Office of Adults with Cognitive and Physical Disability Services) cannot be countermanded by the State Medicaid agency (Maine Care Services) per 42 CFR 483.108, with the exception of appeal determinations made through the system specified in subpart E of 42 CFR 483.204. The mental health and mental retardation authorities and the State Medicaid Agency are part of the Department of Health and Human Services.

SECTION 67 **NURSING FACILITY SERVICES** **ESTABLISHED 7/1/91**
LAST UPDATED 4/25/10

67.05 **POLICIES AND PROCEDURES** (cont.)

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B. NF's may not admit any individual who has not had preadmission screening for mental illness, mental retardation, or other related condition. All applicants to a NF, regardless of payment source (private pay, Medicare, MaineCare or other third-party payor) must be screened with the Level I screen:

1. Preadmission screening is not required in the case of the readmission to a NF of an individual who, after being admitted to the NF, was transferred for care in a hospital. However, such readmissions are subject to a change in condition (CIC) review when indicated.

2. A Level II screen is not required for an individual admitted to a NF directly from a hospital (after receiving acute inpatient care) if the individual requires NF services for the condition for which care was received in the hospital, and the attending physician certifies, before admission to the NF, that the individual is likely to require a NF stay of less than thirty (30) days.

   If an individual who enters a NF as an exempted hospital discharge is later found to require more than thirty (30) days of NF care, a Level II assessment must be conducted if indicated within forty (40) calendar days of admission.

3. A Level II screen may be deferred or waived, as appropriate, for an individual who is likely to require a NF stay of less than thirty (30) days, and if the individual qualifies for an advance categorical determination, as determined by the State Mental Health Authority.

   If an individual who enters a NF as an advance categorical determination and is later found to require more than thirty (30) days of NF care, a Level II assessment must be conducted, if indicated, within forty (40) calendar days of admission.

4. Interfacility transfers are subject to change in condition (CIC) review when indicated. An interfacility transfer occurs when an individual is transferred from one NF to another NF, with or without an intervening hospital stay. In cases of transfer of a resident with MI ,MR or ORC from a NF to a hospital or another NF, the transferring NF is responsible for ensuring that all PAS CIC records and resident assessment reports accompany the transferring resident.

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C. For each resident who has mental illness, mental retardation, or other related condition, a change in condition (CIC) review must be conducted promptly after a significant change in physical or mental condition occurs, in order to determine whether the resident requires

67.05 **POLICIES AND PROCEDURES** (cont.)

the level of services provided by a NF and, if so, whether the individual requires specialized services for MI ,MR, or ORC.

D. The Level I and Level II screening procedures and time frames are described in the Manual issued by the mental health and mental retardation authorities This Manual can be accessed on line at: http://www.maine.gov/dhhs/mh/PASRR/Contents.htm

Any NF applicant known or suspected to have a serious mental illness, as identified by the Level I screen, shall be referred to the mental health authority for a Level II assessment. The applicant shall be notified in writing that the need for specialized services will be determined through a Level II assessment.

Any NF applicant known or suspected to have mental retardation or a related condition, shall be notified in writing and referred to the nearest mental retardation authority Regional Office for a Level II assessment.

The findings of a Level II assessment shall be submitted to the State Medicaid Agency within six (6) to eight (8) working days of the referral.

E. An applicant or resident has the right to appeal the finding of need for specialized services. He/she may request a hearing by submitting a verbal or written request within ten (10) days of receipt of the notification letter or of the final determination decision by writing to the Director, MaineCare Services, #11 State House Station, Augusta, ME 04333-0011.

F. A NF or an entity that has a direct or indirect affiliation or relationship with a NF, may not conduct PAS CIC activities, with the exception of a Level I screen.

G. MaineCare will not cover NF services for any individual found not to require NF services, with the following exception:

Any long term resident who has continuously resided in a NF for at least thirty (30) months before the date of determination, and who requires only specialized services for MI or MR, will be offered the choice of remaining in the NF or of receiving services in an alternate appropriate setting.

H. MaineCare will only reimburse for services furnished after preadmission screening for MI, MR, or ORC has been completed.

I. Failure to implement preadmission screening, in accordance with established procedures, for all NF applicants, regardless of payment

67.05 **POLICIES AND PROCEDURES** (cont.)

source (e.g.: MaineCare, Medicare, private pay, or other third-party payor), shall result in sanctions from MaineCare Services.

67.05-2 **Notice and Preadmission Long Term Care Assessment (MED)**

A. NFs shall provide all applicants for NF services a copy of the Department's official notice that indicates that a Long Term Care assessment is required. The notice shall also indicate that, if the applicant depletes the applicant's resources and applies for MaineCare in the future, the applicant may need to leave the NF if an assessment conducted at that time finds that the applicant is not medically eligible for NF services.

B. Except as specified in C and D below, a preadmission Long Term Care assessment (MED) is required for each applicant, regardless of source of payment, including private pay individuals. The Department or its Authorized Agent shall conduct the assessment using the approved eligibility Assessment Form.

1. The Assessment Form must be completed prior to admission, or, if necessary for reasons of the person's health or safety, following communication with the Office of Elder Services to receive approval for deferral of the mandated assessment, as soon after admission as possible.

2. An applicant shall be informed of available, appropriate, and cost-effective home and community-based services and alternatives to NF placement. The relative costs to the applicant, of each option, shall be explained.

C. For a consumer transferring from a hospital to the NF under Medicare or any other private insurance coverage, the long term care assessment (MED) may be delayed until the exhaustion of their Medicare/private insurance covered NF stay. To ensure MaineCare reimbursement, it is the responsibility of the NF to track each Medicare, Medicare managed care, and private insurance covered admission, and to notify the Department or its Authorized Agent and request an assessment five (5) calendar days prior to the last day of coverage. The Department or its Authorized Agent will conduct an assessment and issue a MaineCare eligibility decision.

The eligibility for MaineCare coverage shall start with the date the eligibility Assessment Form is completed. In a situation where the first twenty (20) day period is reimbursed one hundred percent (100%) by Medicare or other third party insurance, retroactive MaineCare coverage may be granted back to the first day of the end of that period,

67.05 **POLICIES AND PROCEDURES** (cont.)

if an assessment was requested by the Office of Integrated Access and Support prior to the twentieth (20^{th}) day.

D. For a consumer admitted under a Hospice Medicare or MaineCare benefit the PAS screen shall be exempt and the long term care assessment (MED) may be waived for up to the five (5) day benefit period. If the person is receiving the general inpatient care hospice benefit and it is the person's intention to remain in a NF setting, then the assessment can be done prior to the benefit period ending.

If the consumer chooses to stay in the NF beyond the benefit period, the NF must request the Department or its Authorized Agent to conduct an assessment, regardless of the consumer's payment source. For MaineCare coverage, medical eligibility shall start the date the assessment is completed.

67.05-3 **Determination of Eligibility**

A registered nurse trained in conducting assessments with the Department's approved MED form, shall conduct the medical eligibility assessment. The assessment must be performed by the Department or its Authorized Agent. In the process of completing an assessment the nurse assessor shall use professional nursing judgment. The assessor shall, as appropriate within the exercise of professional nursing judgment, consider documentation, perform observations and conduct interviews with the applicant/member, family members, direct care staff, the applicant's/member's physician, and other individuals, and document in the record of the assessment all information considered relevant in the professional judgment of the assessor.

A. **Eligibility from a Hospital**

1. If the applicant is not a MaineCare member, the discharge planner or other designated person shall explore MaineCare financial eligibility and refer the applicant, family member, or guardian to the regional office of the Office of Integrated Access and Support.

2. MaineCare coverage of NF services shall begin only after an applicant is determined medically eligible by the Department or its Authorized Agent using the Assessment Form. Except for Medicare and/or other private insurance covered NF admissions described in Sec. 67.05-2 (C) and (D), the assessment shall be conducted prior to admission to a NF. The hospital shall request an assessment by submitting a complete referral form to the Department or its Authorized Agent. An incomplete form will be returned to the hospital and the assessment delayed until receipt of a complete form. Forms may be faxed. The Department or its Authorized Agent shall complete the medical eligibility Assessment Form within twenty-four (24) hours of the request

67.05 **POLICIES AND PROCEDURES** (cont.)

for an assessment and the eligibility assessment shall not be conducted sooner than twenty-four (24) hours prior to the denial of acute level of care or discharge from a hospital.

3. Applicants who meet the NF medical eligibility criteria, according to the Assessment Form, shall be informed of, and offered the choice of, available, appropriate, and cost-effective home and community-based services and alternatives to NF placement. The relative costs to the consumer of each option must be explained.

4. The applicant (or applicant's guardian, agent or surrogate, as defined in 18-A MRSA Sec. 5-801) shall sign a "choice letter" indicating his or her selection of community-based services or NF placement.

5. If the applicant does not select community-based services, he/she must accept the first available appropriate nursing facility placement within a sixty (60) mile radius of his or her home, or MaineCare reimbursement will cease. If the applicant refuses to accept the placement, the hospital discharge planner must notify the Department, and the Department will issue a ten (10) day notice of intent to terminate services.

   The applicant may accept a placement beyond the sixty (60) miles from home radius, however, this cannot be required. The discharge planner shall document in the medical record all efforts to obtain an appropriate placement.

   If the applicant is a MaineCare and a Medicare member and is eligible for Medicare NF services, he/she shall be admitted to a Medicare certified NF bed, except in the following circumstances:

   a. If the applicant has been a resident in a NF and desires to return to that NF and can receive appropriate care; or

   b. An appropriate Medicare certified NF bed is not available within a sixty (60) mile radius of the applicant's home.

B. **Eligibility from a Nursing Facility**

1. If the resident is not a MaineCare member the NF will explore MaineCare financial eligibility and refer the applicant, family member or guardian to the regional office of the Office of Integrated Access and Support.

2. The NF shall request an eligibility assessment by submitting a complete referral form to the Department or its Authorized

67.05 **POLICIES AND PROCEDURES** (cont.)

Agent. An incomplete form will be returned to the NF and the assessment delayed until receipt of a complete form. The Department or its Authorized Agent shall conduct the medical eligibility assessment with the Department's approved Assessment Form. A Registered Nurse (RN) must conduct the medical eligibility assessment. Applicants who meet the NF medical eligibility criteria, according to the Assessment Form, shall be informed of, and offered the choice of, available, appropriate, and cost-effective home and community-based services and alternatives to NF placement. The relative costs to the patient, of each option, must be explained. The Assessment Form must be completed within five (5) calendar days of the request for an assessment. Faxed forms are acceptable.

3. The applicant (or applicant's guardian, agent or surrogate, as defined in 18-A MRSA Sec. 5-801) shall sign a "choice letter" indicating his or her selection of community based services or NF placement as part of the assessment process and again with each reassessment that follows.

4. For individuals who are expected to remain in the facility following their conversion from Medicare, private pay, or other third-party coverage, to MaineCare coverage, the NF shall request a NF medical eligibility assessment up to five (5) calendar days prior to the exhaustion of their current coverage. A copy of the facility's third-party denial letter indicating the last day of covered services, must be submitted to the Department, or its Authorized Agent. In order to receive MaineCare reimbursement back to the day of exhaustion of benefits, the NF must request a NF medical eligibility assessment no later than five (5) calendar days after the exhaustion of benefits.

5. In the event a non-MaineCare covered resident depletes his or her resources and does not notify the NF in a timely manner to allow compliance with Section 67.05-2 above, (that is to request an assessment within five (5) calendar days before or five (5) calendar days after the qualifying event), MaineCare shall reimburse covered services back to the date of financial eligibility so long as the member is determined medically eligible at the time the MED assessment is completed by the Department or its Authorized Agent and if the NF meets the following conditions:

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   a. Provides documentation which demonstrate quarterly efforts to inform the consumer or responsible party of the availability of MaineCare funding if private resources are exhausted; and

67.05 **POLICIES AND PROCEDURES** (cont.)

b. Provides documentation of ongoing offers of NF staff to work with and assist the consumer or responsible party to submit a MaineCare financial application; and

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c. The NF makes a request for an assessment to the Department or its Authorized Agent within five (5) calendar days before or five (5) calendar days after receipt of notice from the consumer or responsible party that all private funds are depleted.

Requests must be submitted for approval to the Department and include a description of the chronology of events and required documentation from the medical record. Submit request to:

Director, Office of Elder Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

C. **Eligibility from Other Settings**

1. Concurrent with the financial eligibility determination process, the Department or its Authorized Agent shall arrange for a medical eligibility assessment at the applicant's residence.

2. The Department or its Authorized Agent shall conduct the medical eligibility assessment with the Department's approved Assessment Form. A Registered Nurse (RN) must conduct the medical eligibility assessment. Applicants who meet the NF medical eligibility criteria, according to the Assessment Form, shall be informed of, and offered the choice of available, appropriate, and cost-effective home and community-based services and alternatives to NF placement. The relative costs to the applicant of each option, must be explained. The Department or its Authorized Agent must complete the Assessment Form within five (5) calendar days of receipt of a request for an assessment.

D. **Eligibility for Home Care for Certain Disabled Children (Katie Beckett)**

The following criteria are to be used for the determination of home care for certain disabled children age eighteen (18) and under who would be eligible for MaineCare if in a nursing facility:

1. The child meets the medical eligibility requirements for NF services described in Section 67.02-3. The child shall be

67.05 **POLICIES AND PROCEDURES** (cont.)

evaluated in the context of age appropriate development for the "activities of daily living" under Section 67.02-3(B)(2).

2. It is appropriate to provide such care for the child outside an institution;

3. The estimated amount to be expended for medical assistance for the child for such care outside an institution is not greater than the estimated amount expended for medical assistance for the individual within an appropriate institution; and

4. The child meets the criteria described in the Department's MaineCare Eligibility Manual regarding disabled children.

A child's medical eligibility, as defined in Section 67.02-3, for NF level services, is subject to periodic reviews by the Department.

67.05-4 **Continued Stay Review**

A. The NF must submit a complete referral form to the Department or its Authorized Agent to request a reassessment at least five (5) calendar days prior to the end date of the resident's current approved eligibility period in order for a new eligibility period to be established and MaineCare coverage to continue. A resident who continues to meet the eligibility requirements for NF services shall sign a "choice letter" indicating his or her selection of community-based services or continued stay in the NF.

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B. An individual who is classified for NF-BI level of care must continue to meet the eligibility requirements set forth in Section 67.02-5, in addition to the other requirements in Section 67.02, in order for a new NF-BI eligibility period to be approved. The NF must submit a complete referral form to the Department or its Authorized Agent to request a reassessment at least five (5) calendar days prior to the end date of the resident's current approved eligibility period in order for a new eligibility period to be established and MaineCare coverage to continue. Upon reassessment for NF-BI level of care, the assessment required in Section 67.02-5(C) may be waived at the discretion of the Department or its Authorized Agent; however, a current rehabilitation plan of care with specific goals and timeframes must be in place, and there must be evidence indicating the potential for continued improvement.

Effective 4/25/10

C. The reassessment required in Section 67.05-4(A) may be deferred by the Department or its Authorized Agent if: 1) it is the clinical judgment of the assessor that the resident is likely to continue to meet the medical eligibility requirements in Section 67.02-3; and 2) the resident has been in a nursing facility receiving MaineCare coverage for

Effective 4/25/10

67.05 **POLICIES AND PROCEDURES** (cont.)

nursing facility services for at least ninety (90) days (excluding resident-days in the facility under an appeal).

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Reassessments cannot be deferred for members eligible under Section 67.02-5 NF-BI or members classified under Section 67.02-6, Extraordinary Circumstances.

D. The NF is responsible for implementing a systematic review process to monitor the service needs of each resident and to determine whether the resident continues to require a Nursing Facility level of care to the eligibility requirements set forth under Section 67.02. This review process shall be conducted in conjunction with the multidisciplinary team process.

E. The NF is responsible for notifying a resident who no longer requires a Nursing Facility level of care, as defined by the requirements set forth under Section 67.02. The NF shall request the Department or its Authorized Agent to conduct an eligibility assessment to document whether a resident continues to meet the eligibility requirements. See Section 67.05-9 regarding discharge procedures.

F. At the Department's or its Authorized Agent's request, an individual may be referred to the specialized "Geriatric Evaluation Team" for an assessment of his/her cognitive and physical health status. The team shall provide findings and recommendations to the Department or its Authorized Agent and the individual's physician for care plan development.

G. The Department may review at any time a member's eligibility for continued MaineCare reimbursement for NF, NF-BI services or "extraordinary circumstances" pursuant to Section 67.02-6.

67.05-5 **Physician Services**

A physician must personally approve in writing a recommendation that an individual be admitted to a NF. Stamped signatures are unacceptable. The resident must be seen by a physician at least once every thirty (30) days, during the first ninety (90) days after admission to the NF, and at least once every sixty (60) days thereafter.

67.05-6 **Resident Case Mix Assessment**

A. Each resident of a NF, regardless of payment source, shall have a resident assessment that will enable facility staff to develop a plan of care designed to assist the resident to reach their highest practicable level of physical, mental, and psychosocial functioning.

67.05 **POLICIES AND PROCEDURES** (cont.)

The Minimum Data Set (MDS) and matching Resident Assessment Protocols (RAPs) is the Department's approved Resident Assessment Instrument.

B. **Accuracy of Assessments**

1. Each assessment must be conducted or coordinated with the appropriate participation of health professionals.

2. Certification. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the Assessment Form.

3. Penalty for falsification. An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties pursuant to CFR Subpart B - Requirements for Long Term Care Facilities, 42 CFR §483.20(j) in addition to possible criminal liability.

4. Use of independent assessors. If the Department determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph B(3) above, the Department may require (for a period specified by the Department) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the Department.

C. The Department may review all forms used for resident assessments at any time. Quality reviews will be undertaken by the Department for the following reasons:

1. To ensure that assessments are completed accurately, correctly and on a timely basis.

2. To review the need for NF care for any resident.

67.05-7 **Resident Case Mix Classification**

All residents admitted to a NF, regardless of payment source, shall be assessed using the Minimum Data Set (MDS). The MDS provides the basis for resident classification into one of the case mix groups. The MDS does not meet the definition of Assessment Form in Section 67.01-17. An additional group is assigned when assessment data are determined to be incomplete or in error.

Refer to the Principles of Reimbursement for Nursing Facilities for the case mix classification categories.

67.05 **POLICIES AND PROCEDURES** (cont.)

67.05-8 **Admissions Discrimination and Preferential Admission**

Each facility shall have and implement a written policy consistent with State licensing and Federal certification requirements, which shall define the medical services that may be provided in the facility.

Each facility shall have and implement a written antidiscrimination policy consistent with State licensing and Federal certification requirements, which shall include the following:

A. **Provisions for Resident Acceptance**

All NF's shall have written policy stating that the facility will accept residents regardless of race, color, national origin, or reimbursement source. The written policy shall also identify the following: members of the admission committee; medical treatments that cannot be performed by facility staff; and criteria used to determine incompatibility with current residents. In addition:

1. Nursing facilities may not require any third-party payment as a condition of admission, expedited admission or continued stay in a nursing facility.

2. Nursing facilities may not charge, solicit, accept or receive any gift, money, donation or other consideration as a condition of admission, or expedited admission or continued stay.

B. **Preferential Admission**

NFs may preferentially admit residents under the following conditions and shall give preference in the following order:

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1. Any resident whose hospitalization exceeds the approved bed hold period that is paid by MaineCare shall be permitted to be readmitted to the facility immediately upon the first availability of a bed in a semiprivate room in the NF, as long as the resident requires the level of care provided by the facility, and as long as the facility can provide the level of care required by the resident.

2. A facility may preferentially admit anyone who is referred by the Authorized Agent, the Department or the Department’s Office of Adult Mental Health Services (also see Sec. 67.05-1, PAS CIC requirements) if the individual's physical health and safety is at risk and he or she is NF level of care.

3. A NF may also preferentially admit residents under the following conditions (without any specific order of preference):

67.05 **POLICIES AND PROCEDURES** (cont.)

a. A facility that is owned and operated by a religious group or for veterans may preferentially admit all members of that religion or denomination or veteran status.

b. A facility may preferentially admit all persons who have a long-time residence in the area where the facility is located.

c. A facility may preferentially admit anyone referred by a specific hospital with which the facility has a written transfer agreement.

d. A facility may preferentially admit anyone who has a spouse residing in that facility.

e. A facility may preferentially admit anyone who has a signed agreement between their insurance company and the NF.

f. A facility may preferentially admit anyone needing specialized covered services (i.e.: care for a brain injury) provided by that facility or in a distinct part of the facility.

g. A facility may preferentially admit anyone who has a written life-care-contract with the facility or with a continuing care retirement community that has entered into a written agreement with the facility.

C. **Waiting List**

A waiting list for facility admissions must be utilized in admitting residents and must also meet the requirements contained in the Regulations Governing the Licensing and Functioning of Nursing Facilities. Residents shall be admitted on a first-come first-served basis, subject to the exceptions outlined in Section 67.05-8(A) and (B).

1. The waiting list must contain the names of all referrals for admission, regardless of payment source, must be updated as necessary and must indicate the reason(s) why a person was not admitted, or was removed from the list. A facility's decision to admit out of order must be justified with reference to policies established pursuant to Section 67.05-8. A facility's decision not to admit must be justified with reference to a written policy defining the scope of medical services provided.

2. The list must indicate when a resident was admitted and must be maintained in one bound book and be available for public review.

67.05 **POLICIES AND PROCEDURES** (cont.)

3. Facilities may not require verbal or written assurance that potential residents are not eligible, or will not apply for Medicare or MaineCare benefits.

4. Once a person's name has been entered on the waiting list, a facility may require the completion of a reasonable application or interview but may not require any additional activity by the potential resident in order to maintain his/her place on the waiting list.

D. **Continuing Care Retirement Communities**

Any facility which is subject to guidelines contained in 24-A M.R.S.A., §6201 *et seq.* is exempt from compliance with this rule.

67.05-9 **Discharges**

A. **Discharge Tracking Forms**

When a resident is discharged from a nursing facility with no expectation of return, discharged with return anticipated, or discharged prior to completing a MDS, a Discharge Tracking Form is to be completed within seven (7) days of the event. Completion of the discharge tracking form is required upon discharge from a facility, admission to another health care facility, or for hospital stays of twenty-four (24) hours or more. The form is not required for therapeutic or social leaves or for observational stays of less than twenty-four (24) hours. Discharge tracking forms must be electronically submitted at least monthly to the Department or its Authorized Agent.

B. **Reentry Tracking Forms**

Following submission of a discharge tracking form coded as discharged with return anticipated or discharged prior to completion of initial assessment, a reentry tracking form must be completed within seven (7) days of the reentry to the facility. The reentry tracking forms must be electronically submitted at least monthly to the Department or its Authorized Agent.

C. **Discharge Planning Procedure**

1. Each participating NF shall maintain written discharge planning procedures that describe which staff members of the facility will have operational responsibility for discharge planning; and, the manner and methods by which such staff members will function, including their relationship with the facility staff.

67.05 **POLICIES AND PROCEDURES** (cont.)

2. At the time of the resident's discharge, the facility shall provide to those persons responsible for post-discharge care such information as will insure the optimal continuity of care. Examples of such information are: current information relative to diagnosis, prior treatment, rehabilitation potential, physician advice concerning immediate care, and pertinent social information.
3. Nursing facilities must notify the Department, Office of Elder Services, of all MaineCare discharges by submitting the Member Transfer form on the day of discharge. This notification is not required for Medicare discharges where MaineCare covers the co-pay, deductible and/or coinsurance. However, notification is required if a member is enrolled in a Medicare managed care plan and Medicare will be paying the member's daily rate of reimbursement for a period of time. The NF must also notify the Department's Office of Elder Services when the member's Medicare benefits discontinue and MaineCare will again be responsible for the daily rate.

4. If the resident is transferring to another NF, copies of the current MDS assessment, the most recent MED form and all PAS CIC records (Level I, Level II and Annual Resident Reviews) shall be sent along.

5. Individuals who are discharged from a NF to their home or community setting shall be made aware of community resources prior to discharge. A referral may be submitted to the Department or its Authorized Agent for an assessment for long term care services.

D. **Resident Transfer and Discharge Rights**

A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

1. the transfer or discharge is necessary to meet the resident's welfare or medical needs and the resident's welfare or medical needs cannot be met in the facility;

2. the transfer or discharge is appropriate because the resident's health and/or functional abilities has improved sufficiently so the resident no longer needs the services provided by the facility; as determined by the resident's physician or a third party payor including Medicare and/or MaineCare;

3. the safety of individuals in the facility is endangered;

67.05 **POLICIES AND PROCEDURES** (cont.)

4. the health of individuals in the facility would otherwise be endangered as determined by the resident's physician;

5. the resident has failed, after reasonable and appropriate notice, to pay or have paid on his or her behalf (including MaineCare, Medicare) for the stay at the facility. Conversion from private pay rate to payment at the MaineCare rate does not constitute non-payment. For a resident who becomes eligible for MaineCare after admission to a facility, the facility may charge a resident only allowable charges under MaineCare; or

6. the facility ceases to operate. In the event a NF ceases to operate and the member is to be transferred to another NF, the member must accept the first available placement that is appropriate to meet his or her medical care needs within a sixty (60) miles radius of the member's home, (or the NF, if this is considered home) or MaineCare reimbursement will cease. The member may accept a placement beyond the sixty (60) miles radius, however, this cannot be required.

The resident's clinical record shall contain documentation describing the basis for the transfer or discharge. When a resident is transferred or discharged for reasons described in 67.05-9(D)(1) or (2), the resident's clinical record shall contain documentation by the resident's physician that identifies the need for transfer or discharge and Interdisciplinary Care Team planning. The member's clinical record must be documented by a physician if the resident is being discharged for the reasons described in 67.05-9(D)(4). Documentation by a physician is not required if the discharge is based upon the reasons described in 67.05-9(D)(3), (5) or (6).

The facility must demonstrate that appropriate multidisciplinary interventions have been tried and have failed before discharging a resident because of violent behavior.

E. **Pre-transfer and Pre-discharge Notice**

1. In General - Before transferring or discharging of a resident, a nursing facility must -

   a. notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reason(s);

   b. record the reason(s) in the resident's clinical record, including any documentation required in Section 67.05-9(D)(1-6) above; and

67.05 **POLICIES AND PROCEDURES** (cont.)

c. include in the notice the items described in Section 65.05-9(E)(3) below.

2. Timing of Notice - Written notice must be made at least thirty (30) days in advance of the resident's transfer or discharge except:

a. in a case described in Section 67.05-9(D) (3)and (4),

b. in a case described in Section 67.05-9(D)(2) where the resident's health and/or functional abilities improve sufficiently to allow a more immediate transfer or discharge;

c. in a case described in Section 67.05-9(D)(1) where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

d. in a case where a resident has not resided in the facility for thirty (30) days.

In the case of such exceptions, written notice must be given as many days before the date of the transfer or discharge as is practicable.

In addition, oral notice shall be provided immediately to the resident, his/her legal representative, or a family member (if they are able to be contacted) unless the discharge meets the exceptions. (67.05-9(E)(2)(a - d).

3. Items included in notice - Each notice must include:

a. the reason for the transfer or discharge including events that are the basis for such action;

b. the effective date of the transfer or discharge;

c. the location to which the resident is transferred or discharged;

d. notice of the resident’s right to appeal the transfer or discharge as set forth in Section 67.05-9(G);

e. the mailing address and telephone number of the State Long-term Care Ombudsman Program which is: P.O. Box 2723, Augusta, Maine 04333, 1-800-499-0229 (in-state only) and (207) 621-1079 (local and out-of state);

67.05 **POLICIES AND PROCEDURES** (cont.)

f. in the case of resident's with developmental disabilities, the mailing address and telephone number of the Office of Advocacy Services, Department of Health and Human Services, Office of Adults with Cognitive and Physical Disabilities, which is: 40 State House Station, Augusta, Maine 04333-0040, 287-4228; and for residents with mental illness, the advocacy office is "Disability Rights Center of Maine", Office of Adults with Mental Illness, 40 State House Station, Augusta, Maine 04333-0040, 626-2774 or 1-800-452-1948.

g. the resident's right to be represented by him or herself or by legal counsel, a relative, friend or other spokesperson.

F. **Orientation for Transfer or Discharge**

A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility as defined in the Department's "Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities."

1. Sufficient preparation and orientation shall include, a discharge summary that includes -

a. a recapitulation of the resident's stay;

b. a final summary of the resident's status to include an assessment of the resident's current functional and physical abilities at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

c. a post-discharge plan of care developed with the participation of the resident and his or her family (if available), that will assist the resident to adjust to his or her new living environment.

2. Sufficient preparation may include trial visits by the resident to a new location, working with family to ask their assistance in assuring the resident that valued possessions are not left.

G. **Hearings**

A notice of intent to transfer or discharge (see Section 67.05-9(E)) shall include a statement that any resident has the right to appeal a decision to transfer or discharge to the Office of Administrative

67.05 **POLICIES AND PROCEDURES** (cont.)

Hearings, Department of Health and Human Services. To challenge the transfer or discharge, submit a request in writing to the:

The Office of Administrative Hearings
Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

Hearings will be held on an expedited basis and a written decision will be rendered within three (3) working days. The decision by The Office of Administrative Hearings is enforceable following two (2) working days of the written decision, unless the resident has appealed the decision in court. The appeal must be submitted within two (2) working days. A facility decision to transfer or discharge will be upheld if consistent with the standard set forth in Section 67.05-9(D), (E), and (F). The hearing officer may consider violations, by the facility, of federal or state statutes or regulations that may have contributed to the basis for discharge.

A facility may not transfer or discharge a resident until a decision is rendered if that resident has requested a hearing within ten (10) days of receipt of notice unless:

1. the health or safety of individuals is in immediate risk and cannot be otherwise protected until a decision is rendered (see Section 67.05-9(D) (3) and (4));

2. immediate transfer or discharge is necessitated by the resident's urgent medical need (see Section 67.05-9(D)(1)).

Hearings will be held as described in Chapter I of this Manual unless inconsistent with this Section in which case this Section shall govern.

67.05-10 **Quality Assurance**

Each nursing facility shall have in effect a written quality assurance plan that includes, but is not limited to:

1. Utilization Review

2. Infection Control

3. Discharge Planning

As part of utilization review a NF is required to review the necessity for continued stay and discharge planning in accordance with Section 67.

The Department will monitor the NF's compliance with Section 67.

67.05 **POLICIES AND PROCEDURES** (cont.)

Effective 4/25/10

67.05-11 **Prior Approval for Payment of Bed Holds During a Hospitalization**

A. All nursing facilities must provide written information to the member and a family member or legal representative that specifies the Department's bed hold policy and the facility's bed hold policy before the member is transferred to a hospital and at the time of transfer.

B. A NF shall provide a member with the opportunity for readmission following hospitalization, if the individual remains a MaineCare member. The NF must request prior approval on the day of admission to the hospital or the first working day after admission, if admission is on a non-working day by submitting the Department's member transfer form to the Office of Elder Services. If the NF fails to do so, reimbursement will be granted only for the remainder of the allowed days. If the NF fails to notify the Office of Elder Services, the patient shall not be billed for non-reimbursed days.

C. Payment of bed holds for a semi-private room for a short-term hospitalization of the member shall be granted up to ten (10) days (midnights), as long as the member is expected to return to the nursing facility. If a member leaves the hospital and does not return to the NF, MaineCare reimbursement for the bed hold will stop as of the date of discharge from the hospital.

If the member's hospitalization exceeds the ten (10) day (midnights) bed hold period, the resident must receive a medical eligibility assessment prior to continued MaineCare coverage of nursing facility services.

MaineCare eligible members who are admitted to a NF from their home or community living situation and their expected stay is to be less than thirty (30) days in the NF, would not qualify for bed hold days. MaineCare members authorized under extraordinary circumstances (see Section 67.06) or awaiting placement for residential care (see Section 67.06-9) are not eligible for bed hold days. The facility must notify the Office of Elder Services by faxing the member transfer form.

Effective 4/25/10

D. Upon a resident's readmission to a NF, following a hospital stay, the NF must FAX or mail a completed copy of the Member Transfer Form to the Office of Elder Services.

E. If at any point it is determined that the resident will not return to the NF, the Office of Elder Services must be notified and reimbursement for the bed hold will cease.

67.05 **POLICIES AND PROCEDURES** (cont.)

F. Family or friends of a MaineCare-eligible resident may make payment for bed holds in excess of the maximum number of days allowed under MaineCare regulations. This payment may not exceed the usual and customary rate for a bed in a semi-private room.

67.05-12 **Leave of Absence for a MaineCare Member**

All nursing facilities are responsible for informing residents in writing of their right to thirty-six (36) overnight leaves of absence. A leave of absence may not be used to extend a bed hold during a hospital stay. Payment may be made to a facility to reserve a bed for a resident on an overnight leave of absence if the following conditions are met:

A. The resident's plan of care provides for such an absence;

B. The resident takes no more than a total of thirty-six (36) days in leaves of absence during the twelve (12) month period from July 1 through June 30;

C. If at any point it is determined that the resident will not return to the NF, the Office of Elder Services must be notified and reimbursement for the bed will cease.

67.05-13 **Services, Supplies and Equipment**

A. **Routine Services, Supplies and Equipment Included in Regular Rate for Reimbursement**

1. Routine services, supplies, and equipment shall be supplied by the facility as part of the regular rate of reimbursement. Routine services means regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment. (See Chapter II, Section 60, Medical Supplies and Durable Medical Equipment for a list of supplies and equipment provided to members in a NF as part of the regular rate of reimbursement.)

Effective 4/25/10

2. Facilities which serve a special group of the disabled are expected to furnish the equipment and services normally used in their care (e.g., children's wheelchairs) as part of their reasonable cost.

B. **Supplies and Equipment for Which Department May Be Billed by a Supplier or Pharmacy**

Effective 4/25/10

1. Equipment and supplies which, when ordered by a physician, may be payable to a supplier or pharmacy in accordance with the policies established

67.05 **POLICIES AND PROCEDURES** (cont.)

under Section 60 and Section 80 of Chapter II of this Manual.

2. For purposes of reimbursement, acute care general hospitals that are affiliated with the facility through the same corporate structure, or have a NF as a distinct part of a larger institution, may be considered a supplier of these items and must bill the Department as a provider of medical supplies and durable medical equipment for patients who are residents of the hospital-based NF.

C. **Services, Supplies and Equipment Costs Charged to Residents' Personal Funds**

1. **Personal Funds**

Charges may not be imposed against the personal funds of a resident for any item or service for which payment is made under MaineCare. In addition, residents shall not be required to supplement MaineCare payments for items or services that are covered.

Effective 4/25/10

2. **Member Cost of Care**

a. A member's cost of care is determined by OIAS under MaineCare eligibility rules.

b. Routine supplies and personal care items that are provided by the NF under 67.05-13(A), may not be purchased by a member and then deducted from his or her client cost of care.. If a resident has a therapeutic need for a particular brand name item, or product, as documented by the physician, then the NF must provide that brand name item or product to the resident as part of the NF regular rate of reimbursement.

c. The cost of "Less-Than-Effective" drug products, identified under the FDA's Drug Efficacy Study Implementation (DESI) program, may not be deducted from a resident's client cost of care. These drug products are not covered under MaineCare.

d. Drugs of manufacturers not participating in the Rebate Program may not be deducted from a resident's client cost of care. Reimbursement for these drug products is not covered under MaineCare.

e. Some items are covered by MaineCare only for individuals under the age of twenty-one (21). In cases where an individual age twenty-one (21), **or over**, requires an item or service covered by MaineCare only for individuals

67.05 **POLICIES AND PROCEDURES** (cont.)

under age twenty-one (21), the amount to be charged to the client assessment or to the responsible party, shall be limited to the MaineCare rate for that item or service.

f. Eyeglasses for individuals residing in a nursing facility, who are age twenty-one (21), or over, must be obtained through the Vision Care Volume Purchase Contract.

D. **Physical Therapy (PT) and Occupational Therapy (OT) Services**

Physical and occupational therapy services must be directly and specifically related to an active written treatment regimen designed by the physician after any needed consultation with the qualified physical or occupational therapist, and the services must be included in the written plan of care. To constitute physical or occupational therapy, a service furnished to a member must be reasonable and necessary for the treatment of his or her illness or condition. The services must be of such a level of complexity and sophistication, or the condition of the member must be such, that the judgment, specialized knowledge, and skills of a qualified physical or occupational therapist are required.

See Section 68, Occupational Therapy Services and Section 85, Physical Therapy Services of the MaineCare Benefits Manual for licensing criteria of the practitioner and covered services.

1. Limitations

a. MaineCare will not reimburse for more than two (2) hours each of PT and OT per day.

b. PT or OT services can be provided by a home health agency certified as a Medicare provider, or an outpatient department of an acute care hospital, or a licensed independent therapist as defined in Chapter II, Sections 68 and 85 of the MaineCare Benefits Manual.

c. NFs may bill for services of PT and/or OT on their staff or under a contract with them. Reimbursement for services provided by a licensed independent physical or occupational therapist will be limited to the maximum allowance as defined in Chapter III, Sections 68 and 85 of the MaineCare Benefits Manual.

d. For purposes of reimbursement, acute care general hospitals that are affiliated with the facility through the same corporate structure, or have a NF as a distinct part of a larger institution, must bill the Department as a provider of physical or

67.05 **POLICIES AND PROCEDURES** (cont.)

occupational therapy services on the NF's billing form for patients who are residents of the hospital-based NF.

2. Reimbursement for PT and OT Consultations

a. Consultation provided to a NF must be reimbursed at a reasonable cost.

b. Types of consultation that may be approved include:

1. In-service education programs for staff members who have not been trained to carry out procedures that may be delegated by a physical or occupational therapist; and

2. Professional consultation provided to administrators with respect to purchasing equipment or modification of a physical plant to meet the needs of individuals.

E. **Speech and Hearing Services**

1. All covered services provided under Section 109 of the MaineCare Benefits Manual must be ordered or requested in writing by a physician, physician assistant, or advanced practice registered nurse as allowed by the respective licensing authority and his or her scope of practice.

2. Covered speech-language pathology services for members aged twenty-one (21) or older are also limited to those members who have been assessed to have rehabilitation potential as defined in Section 67.01-26 or to those who have demonstrated medical necessity for speech therapy to avoid a significant deterioration in ability to communicate orally, safely swallow or masticate. A member's rehabilitation potential must originate from a physician or primary care provider.

Effective 4/25/10

3. Adult members (age twenty-one (21) and over), must have an initial assessment by a physician or primary care provider that documents that the member has experienced a significant decline in his/her ability to communicate orally, safely swallow or masticate, and that the member's condition is expected to improve significantly in a reasonable, predictable period of time as a result of the prescribed treatment plan.

4. One initial evaluation of the member is covered per provider per year. The member must receive an initial evaluation by a speech-language pathologist annually that supports the physician or

67.05 **POLICIES AND PROCEDURES** (cont.)

primary care provider's determination that rehabilitation potential exists.

5. If speech-language pathology services are to be continued beyond a period of six (6) months, a re- evaluation by a speech-language pathologist must be completed every sixth month from the initial determination of eligibility, in order to determine that eligibility continues to exist. A report of the results of the speech-language pathologist's six-month re-evaluation must be sent to the member's physician or primary care provider, who will use that information to decide if eligibility continues to exist. If the physician or primary care provider agrees in writing that eligibility continues to exist, the member may continue to receive speech-language pathology services for an additional six (6) month period.

Effective 4/25/10

6. Limitations

   a. Speech and hearing services when provided in a NF setting, will be reimbursable to the following types of providers only: a home health agency certified as a Medicare provider, or a speech and hearing clinic certified as a Medicare provider, or a licensed speech-language pathologist, or audiologist, or a speech and hearing agency as defined in Section 109 of the MaineCare Benefits Manual.

   b. NFs may bill for services of a speech-language pathologist or audiologist on their staff or under a contract with them. Reimbursement for services provided by a speech-language pathologist or audiologist will be limited to the maximum allowance as defined in Chapter III, Section 109 of the MaineCare Benefits Manual.

   c. For purposes of reimbursement, acute care general hospitals that are affiliated with the facility through the same corporate structure, or have a NF, as a distinct part of a larger institution, must bill the Department as a provider of speech and hearing services on the NF's billing form for members who are residents of the hospital-based NF.

7. Reimbursement for Consultation Services

   Types of consultation that may be approved include: In-service education programs for staff members who have not been trained to carry out procedures and principles developed by the licensed speech pathologist and/or audiologist.

67.05 **POLICIES AND PROCEDURES** (cont.)

F. **Mental Health Services**

Mental Health Services are covered when those services meet all the following conditions:

1. The services must be of a level of less intensity than those defined as specialized services;

2. The services must be specifically designed by a plan of care developed in response to the findings and recommendations of PAS CIC and approved by the NF interdisciplinary team or, for individuals exempt from PAS, the services must be specifically designed by a plan of care developed in response to the findings and recommendations of, and approved by, the NF interdisciplinary team;

Effective 4/25/10

3. The service must be reasonable and necessary for the treatment of the individual's mental illness;

4. The services must be of a level that the skills and expertise of a mental health professional are required;

5. The services must be provided by an individual appropriately licensed or certified in the State or province in which he or she practices and practicing within the scope of that licensure or certification. A clinician includes the following: licensed clinical professional counselor (LCPC); licensed clinical professional counselor-conditional (LCPC-conditional); licensed clinical social worker (LCSW); licensed master social worker conditional clinical (LMSW-conditional clinical); licensed marriage and family counselor (LMFT); licensed marriage and family counselor-conditional (LMFT-conditional); physician; psychiatrist; advanced practice registered nurse psychiatric and mental health nurse practitioner (APRN-PMH-NP); advanced practice registered nurse psychiatric and mental health clinical nurse specialists (APRN-PMH-CNS); psych examiner, RNC, or licensed clinical psychologist.

6. The services must be provided with the expectation that there will be improvement in mental, psychosocial and functional abilities;

7. Mental health services will include consultation with and education of staff in the implementation of the treatment plan recommendations;

8. Mental health services in a NF setting will be reimbursed when ordered by a physician; and

67.05 **POLICIES AND PROCEDURES** (cont.)

9. Mental health services must be provided and reimbursed in accordance with the relevant sections of the MBM and Chapter III of this Section, Principles of Reimbursement for Nursing Facility Services.

Effective 4/1/10

G. **Services for Individuals with Mental Retardation or Other Related Condition**

Community support services are covered for those members residing in the NF who meet the eligibility criteria under Section 21 or have an "other related condition" as defined in 67.01-27 above. The services must meet all the requirements outlined below:

1. The community support services are designed to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well being. These services focus on community inclusion, personal development, and support in areas of daily living skills if necessary.

2. The services are provided by individuals who have successfully completed the Direct Support Professional (DSP) curriculum or the Maine College of Direct Support.

3. All services delivered are written and documented in the member's plan of care.

4. The services must be provided and reimbursed in accordance with Chapter III, Section 67, Principles of Reimbursement for Nursing Facility Services, Subsection 70, Special Service Allowance.

H. **Services for Individuals with a Brain Injury (BI)**

1. A nursing facility that has Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation may be designated by the Department as a provider of service for individuals with a brain injury.

2. The Department or its Authorized Agent will review each individual's need for BI services at least annually, based upon the criteria set forth in 67.02.

   Additionally, the member must show measurable improvement in a reasonable, and generally predictable, period of time. Once it is established that the restorative potential has been reached, and maintenance rehabilitation is required, the member shall be transferred to an appropriate setting.

67.05 **POLICIES AND PROCEDURES** (cont.)

3. A nursing facility providing BI Services shall provide a program of goal-oriented, comprehensive, interdisciplinary and coordinated services directed at restoring an individual to the optimal level of physical, cognitive, and behavioral functioning. Covered services include medical, rehabilitative, and social services provided by appropriately licensed or qualified staff as defined in the Principles of Reimbursement for Nursing Facilities.

Reimbursement for all NF-BI services will be included in the per diem rate, as described in the Principles of Reimbursement for Nursing Facilities. Members classified for NF-BI are prohibited from receiving coverage for services under Section 102, Rehabilitative Services, as long as the member is a NF-BI resident.

H. **Pharmaceutical Services**

All nursing facilities shall comply with State and Federal regulations that govern obtaining, dispensing and administering drugs and biologicals. Refer to the "Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities" for rules regarding pharmaceutical services.

A pharmacy affiliated through common ownership or control with a hospital and/or nursing facility is allowed to dispense covered MaineCare prescription drugs to MaineCare members in that facility. The drugs must be dispensed by a registered pharmacist, according to dispensing regulations. Drugs are to be billed in accordance with the Department's billing guidelines and drug claim processing system, at Average Wholesale Price (AWP) without professional fee. (Also see Section 80, Pharmacy Services.)

I. **Respiratory Therapy Services**

1. The following respiratory therapy services are included in the facility's per diem rate and shall not be billed separately:

   a. Maintenance of artificial airways;

   b. Therapeutic administration and monitoring of medical gases (especially oxygen), pharmacological active mists and aerosols;

   c. Bronchial hygiene therapy, including deep breathing and coughing exercises, IPPB, postural drainage, chest percussion and vibration, and nasotrachael suctioning; and

67.05 **POLICIES AND PROCEDURES** (cont.)

d. periodic assessment and monitoring of acute and chronically ill members for indications for respiratory therapy services.

2. The following services shall not be provided by the direct care staff of the facility, but rather by the appropriate professional and shall be billed separately:

a. diagnostic tests for evaluation by a physician (e.g.: pulmonary function tests, spirometry, and blood gas analysis); and

b. pulmonary rehabilitation that includes exercise conditioning, breathing retraining, and patient education regarding the management of the member's respiratory problem.

J. **Other Services**

The attending physician's order is required for all other types of services provided in a NF (e.g.: psychological services, podiatric services, etc.). The individual providing the service shall bill in accordance with the policies and procedures in the section of this Manual that apply to his or her specialty.

67.05-14 **Transportation to Services Outside of the Nursing Facility**

A. **Arranging or Providing Transportation**

NF's are required to assist members in gaining access to vision, hearing, or other medically necessary MaineCare services by making appointments, and providing or arranging for transportation. To enable a NF to provide transportation, the reasonable costs of operating one (1) motor vehicle is an allowable cost in the facility's reimbursement rate (as set forth in this Section, Chapter III, Principles of Reimbursement for Nursing Facilities). NF's must use their agency vehicle to transport members whenever possible. Each time a member is transported by someone other than a family member/friend, or the NF's agency vehicle, and for which MaineCare reimbursement will be sought, the member's record must document why the NF vehicle was not used.

B. **Transportation Agency**

When a member requires transportation to a MaineCare covered service, and the NF or a family member/friend is unable to provide it and the NF has documented why the transportation cannot be provided, then the MaineCare transportation agency must be called to make travel arrangements. NF staffing shortages should not be an ongoing reason for use of the transportation agency services. It is the expectation that the NF

67.05 **POLICIES AND PROCEDURES** (cont.)

is fully staffed and a need to use a transportation agency due to unavailable staff would not occur frequently.

1. For all appointments and routine medical services except 67.05-14(B) (2) below, such as, but not limited to: dialysis; chemotherapy; and radiation therapy; the transportation agency must request prior authorization (as set forth in Section 113, Transportation Services, MBM) for transportation.

2. The only exception is when the services of a wheelchair van are medically necessary, in which case, the NF must call a full service transportation agency and the agency will arrange for this transportation as needed, if:

   a. the transportation agency has a formal agreement with a MaineCare enrolled wheelchair van provider in the catchment area; and

   b. the NF does not own a vehicle that can accommodate a wheelchair. (e.g. the member is not able to transfer from a wheelchair to a car or van that is owned by the NF) The NF must document in the member's medical record if this situation occurs.

   The transportation agency must work with the NFs to coordinate member appointments to utilize the available resources in the most cost effective manner. The transportation agency must bill MaineCare directly with the procedure codes assigned to them.

67.05-15 **Flu and Pneumonia Vaccinations**

Upon admission, and annually every fall, each resident’s immunization status shall be updated, regardless of payor. Unless medically contraindicated or refused, the standard of care is to administer an annual flu (influenza) vaccination in the fall; and a pneumonia (pneumococcal) vaccination, that may be repeated no more than every five (5) years (other immunizations should also be reviewed and updated as necessary). As with any treatment, the resident has the right to refuse the vaccination. Each vaccination must be documented in the resident’s medical record. Each vaccination refusal by the resident (or guardian, agent or surrogate, as defined in 18-A MRSA Sec. 5-801) must also be documented in the resident’s record. Annually, the NF shall report to the Department, in a format specified by the Department, the number of residents, number and type of vaccinations administered, and the number of refusals for the reporting period.

SECTION 67 **NURSING FACILITY SERVICES** **ESTABLISHED 7/1/91**
LAST UPDATED 4/25/10

67.05 **POLICIES AND PROCEDURES** (cont.)

67.05-16 **Respite Services**

A MaineCare waiver member may be admitted to a NF in order to receive "waiver" respite services for no more than thirty (30) days annually. The Medical Eligibility Determination (MED) assessment and the PAS screen are **NOT** required for a respite admission reimbursed by waiver funds. Respite services for a MaineCare home and community based waiver services member will be authorized and reimbursed through Section 19, Home and Community Based Benefits for the Elderly and for Adults with Disabilities, of the MaineCare Benefits Manual. If the member applies to remain in the NF, MaineCare coverage for NF services shall begin only after all of the requirements in Sec. 67.02 have been met and a classification period has been authorized by the Department or its Authorized Agent.

67.05-17 **Non-Covered Services**

A. Payment by a relative of an additional amount to enable a member to obtain non-covered services such as a private room (single bed), telephone, television, and authorized bed reservation days is permitted. However, the additional charge for noncovered services shall not exceed the charge to private pay residents. The supplement for a private room shall be no more than the difference between the private pay rate for a semi-private room and a private room. There shall be a signed statement by the relative making the additional payment that he/she was notified and agreed to the payment for non-covered services before those services were provided.

B. A private room is a noncovered service under the MaineCare program, but if there is a medical necessity for a private room, the nursing facility must make one available. However, reimbursement will be made only at the MaineCare semi-private room rate.

Effective 4/1/10

C. Specialized services, as determined by a PAS CIC assessment, for NF residents diagnosed with mental illness, mental retardation, or other related condition, are noncovered services under Section 67, Nursing Facility Services. (Also see Section 67.05-13(F)and (G) for covered MI/MR services).

D. PT and OT therapy services related to activities for the general good and welfare of resident, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute physical therapy for MaineCare purposes.

E. Maintenance therapy (repetitive services not requiring the skills of a qualified physical or occupational therapist or the use of complex and sophisticated physical or occupational therapy procedures) is not a covered service, except as provided in Section 67.05-13(D).

67.05 **POLICIES AND PROCEDURES** (cont.)

F. Services provided in the absence of a valid MED form completed by the Department or its Authorized Agent.

G. Services that are provided outside an approved classification period.

67.05-18 **Right of Appeal**

The following individuals may request an administrative hearing if aggrieved by a decision of the Department as set forth in this section.

A. **The Member, His or Her Family or Responsible Person**

An appeal may be made by the member, his or her family, or responsible person or the attending physician on behalf of the member, for any classification decision. In order to appeal, the member should state by letter his or her reasons for disagreement with the classification and any other pertinent information. This letter shall be addressed to the Director of the Office of Elder Services, Department of Health and Human Services, 11 State House Station, Augusta, Maine 04333-0011.

B. **The Provider**

Providers may request a hearing when aggrieved by a decision of the Department as set forth in Chapter I of this Manual. The procedure for administrative hearings is more specifically set forth in Chapter I of this Manual.

67.05-19 **Freedom of Choice**

If a nursing facility contracts with or utilizes a single source of qualified outside resources such as pharmacy services, members must be given a choice of using this particular service or another qualified resource.

67.05-20 **Program Integrity**

All providers are subject to the Department's Program Integrity activities. See Chapter I, General Administrative Policies and Procedures, Section 1.18 of the MBM for rules governing these functions.

67.05-21 **Confidentiality**

The disclosure of information regarding individuals participating in the MaineCare program is strictly limited to purposes directly connected with the administration of the MaineCare program. Providers shall maintain the confidentiality of information regarding these individuals in accordance with 42 CFR §431.300 et seq. and other applicable sections of State and Federal law and regulation.

SECTION 67 **NURSING FACILITY SERVICES** **ESTABLISHED 7/1/91**
LAST UPDATED 4/25/10

67.06 **REIMBURSEMENT**

A. Nursing facilities are reimbursed in accordance with this Section, Chapter III, Principles of Reimbursement for Nursing Facilities.

1. Except for nursing facilities which provide brain injury services, reimbursement for ancillary services, including those provided by a NF that is a distinct part of a larger institution, such as medical supplies, physical therapy, occupational therapy, speech and hearing services, respiratory therapy, and pharmacy services is based upon reasonable cost or the maximum allowance.

2. Brain Injury (BI) services shall be reimbursed pursuant to the "Intensive Rehabilitation NF Services for Brain Injured Individuals" section of the Principles of Reimbursement only when: a) the member is classified, by the Department or its Authorized Agent, NF-BI level pursuant to Section 67.02-5 and all relevant requirements; b) the services were provided during an approved NF-BI classification period; and c) the BI services were delivered in a CARF accredited facility (unless waived by the Department for an authorized out-of-state placement).

Effective 4/25/10

3. Nursing facilities will be reimbursed under Chapter 115, Principles of Reimbursement for Residential Care Facilities, for those members qualifying for continued NF stay under Section 67.02-9.

B. In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek from any other sources payment for the rendered service prior to billing the MaineCare Program.

C. Nursing Facilities may not accept or receive payment for covered services in addition to the MaineCare payment.

SECTION 67 **NURSING FACILITY SERVICES** **ESTABLISHED 7/1/91**

LAST UPDATED 4/25/10

Appendix 1

Assessment Scales		
Disability Rating Scale (DRS)		
Category	**Item**	**Instructions**
Arousability, Awareness and Responsivity	Eye Opening	0 = *spontaneous* 1 = *to speech* 2 = *to pain* 3 = *none*
	Communication Ability	0 = *oriented* 1 = *confused* 2 = *inappropriate* 3 = *incomprehensible* 4 = *none*
	Motor Response	0 = *obeying* 1 = *localizing* 2 = *withdrawing* 3 = *flexing* 4 = *extending* 5 = *none*
Cognitive Ability for Self Care Activities	Feeding	0 = *complete* 1 = *partial* 2 = *minimal* 3 = *none*
	Toileting	0 = *complete* 1 = *partial* 2 = *minimal* 3 = *none*
	Grooming	0 = *complete* 1 = *partial* 2 = *minimal* 3 = *none*
Dependence on Others	Level of Functioning	0 = *completely independent* 1 = *independent in special environment* 2 = *mildly dependent* 3 = *moderately dependent* 4 = *markedly dependent* 5 = *totally dependent*
Psychosocial Adaptability	Employability	0 = *not restricted* 1 = *selected jobs* 2 = *sheltered workshop (non-competitive)* 3 = *not employable*
	Total DR Score	

Rappaport et al., (1982). Disability rating scale for severe head trauma patients: coma to community. Archives of Physical Medicine and Rehabilitation, 63: 118-123

Appendix 1 (cont.)

Total DR Score	Level of Disability
0	None
1	Mild
2-3	Partial
4-6	Moderate
7-11	Moderately Severe
12-16	Severe
17-21	Extremely Severe
22-24	Vegetative State
25-29	Extreme Vegetative State

Rappaport et al., (1982). Disability rating scale for severe head trauma patients: coma to community. Archives of Physical Medicine and Rehabilitation, 63: 118-123