MyCare Ohio

Prior Authorization and Level of Care for **Medicare** Nursing Facility Stays

OHIO DEPARTMENT OF MEDICAID OCTOBER 2018

This guide is intended to be used by nursing facilities when an individual enrolled in the MyCare Ohio Program is admitted to a nursing facility (NF) and **Medicare** is paying for the NF stay. Outlined below are the prior authorization (PA) processes for each MyCare Ohio Plan (MCOP). Level of care is not applicable to this type of stay due to Medicare being the source of payment.

Is a Prior Authorization required for a Medicare covered NF stay?

Yes, a PA is required by every MCOP for Medicare skilled stays (e.g. when Medicare is paying for the NF stay).

What should the NF submit when requesting a Prior Authorization for a Medicare covered NF stay?

Demographic information, clinical information and any supporting documentation. This is inclusive of History & Physical, medications, wound treatment, therapy notes from all disciplines, discharge planning goals, estimated date of discharge and any barriers to reach goals/discharge.

What is the Prior Authorization determination process for a Medicare covered NF stay?

The MCOP will complete a desk review of the information submitted using Medicare, MCG or Interqual guidelines (depending on the plan).

What is the NF required to submit for a continued stay review (e.g. expiring authorization)?

Demographic information, clinical information and any supporting documentation. This is inclusive of History & Physical, medications, wound treatment, therapy notes from all disciplines, discharge planning goals, estimated date of discharge and any barriers to reach goals/discharge.

What does the NF do when a member's benefit switches from Medicare to Medicaid?

When the payer source switches from Medicare to Medicaid, the NF should follow the level of care or prior authorization processes outlined in the MyCare Ohio Prior Authorization and Level of Care for **Medicaid** Nursing Facility Stays section this document (page 3).

*See next page for plan specific responses related to PA requests and LOC determinations for **Medicare** covered NF stays for individuals enrolled in MyCare Ohio.*

MyCare Ohio – **Medicare** Covered NF Stay – Plan Specific Information for Requesting PA

MCOP Plan	Aetna	Buckeye	CareSource	Molina	United
How does the NF request a PA from your MCOP?	The facility can call or fax the request for PA. The UM fax number is (855) 734-9393 and telephone number is (855) 364-0974 (option 2, and then option 4).	PA request form is online: www.buckeyehealthplan.com/content/dam/centene/Buckeye/medicaid/pdfs/OH-PAF-0637_May2016_IP.pdf. Request can be submitted by phone at (866) 246-4359, by fax at (877) 861-6722, or by online at www.buckeyehealthplan.com/providers.html.	Submit the information by fax to (844) 417-6157 or via email to MMMA@caresource.com	The PA request form can be found at www.molinahealthcare.com/providers/oh/medicaid/forms/Pages/fuf.aspx. The PA request form should be submitted to (877) 708-2116.	Contact our Prior Authorization Department by phone at (800) 366-7304 or by fax at (866) 839-6454 after the first 3 days for medical necessity.
How long does it take to get a PA decision from your plan?	Urgent/Expedited requests are handled as expeditiously as the member's health condition requires, but no later than 48 hours after request received.	Standard turnaround time is 24 business hours, and no more than 48 business hours after all pertinent info has been received.	Standard turnaround time is 24 business hours, and no more than 48 business hours after all pertinent info has been received.	Urgent/Expedited requests are handled as soon as medically indicated, with maximum of 48 hours after request is received. Can be extended up to 72 hours if additional info is required.	Standard turnaround time is 24 business hours.
What info will be sent to the NF following a PA request?	Fax is sent with the determination to the NF	Phone call and/or fax notification	Fax notification of days approved, next review date and auth. number	Verbal and/or fax notification of decision	Verbal notification of decision and communication log is faxed to NF
How often does the MCOP verify the member's authorization?	Continued authorization of a skilled stay under Medicare would be based on concurrent review.	Authorization verified based on Interqual guidelines.	Continued authorization of a skilled stay under Medicare would be based on concurrent review.	Authorization verified based on MCG guidelines.	Authorization verified based on MCG guidelines.

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Prior Authorization and Level of Care for **Medicaid** Nursing Facility Stays

OHIO DEPARTMENT OF MEDICAID OCTOBER 2018

This guide is intended to be used by nursing facilities when an individual enrolled in the MyCare Ohio Program is admitted to a nursing facility (NF) and **Medicaid** (e.g. the Mycare Ohio plan) is paying for the NF stay. Outlined below are the prior authorization (PA) and level of care (LOC) processes for each MyCare Ohio Plan (MCOP).

For dually eligible nursing facility residents, skilled care will generally be covered and paid for under the Medicare benefit (see pages 1-2 of this document). In general, Medicaid is not the payer source for a dually eligible individual that needs skilled nursing facility care. Outlined below is the prior authorization process for an individual that has exhausted their Medicare skilled stay benefit, but still requires skilled care and meets the Medicaid definition of skilled level of care.

Is a Prior Authorization required for a Medicaid covered NF stay?

- A PA is **not** required for an individual who meets an **intermediate** LOC as described in OAC rule 5160-3-08. If an individual meets an intermediate LOC, the NF only needs to notify the appropriate MCOP of admission.
- A PA **is** required for an individual who meets a **skilled** LOC as described in OAC rule 5160-3-08 and for **respite** stays.

What should the NF submit when requesting a PA for a Medicaid covered NF stay?

*If an individual meets a **skilled** LOC or is being admitted for **respite***, the NF should submit demographic information, clinical information, documentation to prove compliance with PASRR requirements [e.g. PASRR forms including PAS ID or RR results (if applicable) or PASRR Level II assessment results (if applicable)], and any supporting documentation. This is inclusive of History & Physical, medications, wound treatment, therapy notes from all disciplines, discharge planning goals, estimated date of discharge, and any barriers to reach goals/discharge.

What should the NF submit when requesting a LOC for a Medicaid covered NF stay?

*If an individual meets an **intermediate** LOC*, the NF should submit demographic information, documentation to prove compliance with PASRR requirements [e.g. PASRR forms including PAS ID or RR results (if applicable) or PASRR Level II assessment results (if applicable)], and clinical information including diagnosis list, medication list, MDS section G, information that supports ADL/care needs, and History & Physical signed by the MD. The NF should also submit the name and contact information for member's Authorized Representative, and the contact information for a NF representative.

What are the PA and LOC determination processes?

- ***If an individual meets skilled LOC*** **-** Prior authorizations requests are completed by desk review, and level of care will be determined as part of the PA process.
- ***If an individual meets intermediate LOC*** **-** LOC requests are completed by desk review of member information. If additional information is needed, the assigned care manager will complete a face-to-face visit with the member to evaluate their needs. This information is provided to the desk reviewer to complete the LOC request.

How long does it take to get a PA or LOC decision from the MCOP?

- Prior authorizations are determined in accordance with ORC 5160.34. Expedited PA requests are decided within 48 hours, and standard PA requests are decided within 10 calendar days. For most plans, standard turnaround time is 24 business hours.
- LOC requests are determined in accordance with OAC rule 5160-3-14, pending receipt of all required information.

How often does the MCOP verify an individual's LOC?

For individuals determined to meet an intermediate LOC, the MCOP will verify LOC at least annually, but LOC may be reviewed upon request of the NF, or if there is any significant change of condition as determined by the Case Manager's assessment.

If the MCOP has issued a time-limited level of care due to PASRR Level II results, or while the PASRR Level II assessment is pending, and results indicate that NF placement is not acceptable, then the NF shall work with the care manager to support the member's transition from the facility.

When are continued stay reviews (e.g. expiring prior authorizations) completed?

MCOPs will perform continued stay reviews when prior authorizations for respite stays and Medicaid covered stays for individuals meeting a skilled level of care are expiring to confirm continued medical necessity for NF services. Level of care may also be reevaluated during a continued stay review. All MCOPs include an end date for the previous authorization on their determination letter. This is the date by which the NF should have their continued stay review completed. The authorization spans differ by plan but are explicitly indicated on each plan's PA determination letter.

If the MCOP has issued a time-limited prior authorization due to PASRR Level II results, or while the PASRR Level II assessment is pending, and results indicate that NF placement is not acceptable, then the NF shall work with the care manager to support the member's transition from the facility.

What is required of the NF for a continued stay review (e.g. expiring PA authorization)?

The NF should submit demographic information, clinical information, and any supporting documentation. This is inclusive of History & Physical, medications, wound treatment, therapy notes from all disciplines, discharge planning goals, estimated date of discharge, and any barriers to reach goals/discharge.

*See next page for plan specific responses related to PA requests and LOC determinations for **Medicaid** covered NF stays for individuals enrolled in MyCare Ohio.*

MyCare Ohio – **Medicaid** Covered NF Stay – Plan Specific Information for Requesting PA or LOC

MCOP Plan	Aetna	Buckeye	CareSource	Molina	United
How does the NF request a PA* from your MCOP? *only for individuals who meet a **skilled LOC criteria** based on OAC rule	The facility can call or fax the request for PA. The UM fax number is (855) 734-9393 and telephone number is (855) 364-0974 (option 2, and then option 4).	PA request form is online: www.buckeyehealthplan.com/content/dam/centene/Buckeye/medicaid/pdfs/OH-PAF-0637_May2016_IP.pdf. Request can be submitted by phone at (866) 246-4359, by fax at (877) 861-6722, or by online at www.buckeyehealthplan.com/providers.html.	Submit the information by fax to (844) 417-6157 or via email to MMMA@caresource.com	The PA request form can be found at www.molinahealthcare.com/providers/oh/medicaid/forms/Pages/fuf.aspx. The PA request form should be submitted to (877) 708-2116.	Contact our Prior Authorization Department by phone at (800) 366-7304 or by fax at (866) 839-6454 after the first 3 days for medical necessity.
How does the NF request a LOC* determination from your MCOP? *only for individuals who meet **intermediate LOC criteria** based on OAC rule	Request should be faxed to (959) 282-1848 for processing.	Request is made to a Care Manager for a face-to-face visit and/or assessment to complete LOC determination.	Request should be faxed to (844) 417-6157 Attn: Transitions Coordinator.	Requests should be sent by email to NFMCOPMailbox@molinahealthcare.com.	Notify the UHCCP care manager for level of care determination.
What info will be sent to the NF following a PA* or LOC request? *PA notifications will include an authorization number and authorized date span	• **Intermediate LOC:** LOC determination is given in the form of a faxed document to NF • **Skilled LOC:** Fax is sent with the determination to the NF	• **Intermediate LOC:** Authorization letter that includes all applicable authorization information (auth. number and span) • **Skilled LOC:** Phone call and fax notification	• **Intermediate LOC:** LOC determination is securely e-faxed to the NF • **Skilled LOC:** Fax notification of days approved, next review date and auth. number	• **Intermediate LOC:** Copy of LOC determination form • **Skilled LOC:** Verbal and fax notification of decision	• **Intermediate LOC:** LOC determination letter is sent • **Skilled LOC:** Verbal notification of decision and communication log is faxed to NF