

**PRIOR AUTHORIZATION ELIMINATION/MDS ASSESSEMENT
QUESTIONS AND ANSWERS**

1. What happens to MC9-NF's and MC10's submitted prior to May 1st, 2013, will the nursing facility get them back?

They will not be returned to facilities. You may submit the claim on or after May 1, 2013 without a previously submitted prior authorization response.

2. Are there still services which require a prior-authorization?

Nursing Facility services that require prior authorization for Medicaid payment are:

- NF Providers that are located outside of the State of Nebraska;
- NF Providers that provide services for Long Term Care clients with special needs who contract with Medicaid & Long-Term Care to provide the special needs care; and
- Rural Hospitals requesting Swing Bed hospital care.

3. Is the Senior Care Options (SCO) screening still a requirement?

- Yes, SCO screening is required by Nebraska Medicaid regulation that each individual age 65+ who is requesting Medicaid funding of nursing facility services be referred to Senior Care Options.
- Form MC9-NF will no longer be used by Senior Care Options staff for prior authorization of nursing facility services. Instead, each Area Agency on Aging will provide written verification on agency letterhead.
- The nursing facility payment effective date cannot be before the date of SCO referral for clients who were Medicaid-eligible at the time of referral to SCO, and cannot be before the first date of Medicaid coverage for individuals who were pending Medicaid eligibility at the time of referral to SCO.

4. In the cases where the client is Medicaid pending and the Senior Care Options determination has been issued on an MC-9NF waiting for the Medicaid to open, is the nursing facility required to have the SCO replacement verification if the Medicaid case is opened after May 1st?

The nursing facility will be required to have either the MC-9NF OR the new SCO replacement document. Either is sufficient and if the client becomes eligible after May 1st the facility would just file the MC-9NF as their documentation that the screening was done.

5. What are the Nebraska Medicaid Minimum Data Set (MDS) Requirements?

These requirements can be found at: <http://dhhs.ne.gov/medicaid/Documents/PB1327.pdf>

6. In a case where a patient's Medicare stay ended and the nursing facility entered the Medicare Begin Date on the MDS assessment but their next assessment isn't due for a while, how does the nursing facility notify Medicaid of the Medicare End Date?

If the Medicare stay comes to an end prior to the next due date of an OBRA assessment, the Medicare End Date can be reported by emailing the resident Medicaid number and the Medicare End Date to the former MC-10 email address dhhs.MFPA@nebraska.gov.

7. What client information will the claim edit against with the absence of a prior authorization number?

- Medicaid Identification Number
- Medicaid Eligibility date
- Date of Birth
- MDS admission and discharge dates
- MDS assessment history
- PASRR date and result
- SCO screen date
- Medicare begin and end dates
- Managed Care begin and end dates
- Other Medicaid claims submitted

8. If a claim paid incorrectly, how long does the nursing facility have to submit an adjustment on a claim?

If a claim adjustment is requested as a result of a provider MDS error, it must occur within the timeframes for requesting any Medicaid claim adjustment. The MDS must be corrected and an adjustment requested within the 90 day timeframe as noted in Medicaid policy 471 NAC 3-002.04 which can be viewed on the Medicaid website at:

http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-03.pdf

9. In a case where the patient has a different DOB (date of birth), SSN, etc. than Medicaid, how does the nursing facility fix this?

Nebraska Medicaid automated the validation of this information for Medicaid residents in order to make claim payment. If the correct date of birth is in the nursing facility's system, the Medicaid eligibility system will need to be corrected. If the nursing facility believes that Nebraska Medicaid has the incorrect birthdate in the system, please contact AccessNebraska via web access at www.ACCESSNebraska.ne.gov or phone at 800-383-4278 in order to confirm/correct the date of birth for this resident. If the correct date of birth is in the Medicaid eligibility system, the assessment will need to be modified by the nursing facility.

10. What is the difference between an entry and a re-entry?

When a resident *reenters* the facility after a hospital stay and the bed was held for the resident, verify that the Entry tracking form submitted indicates a **reentry** versus a **new admission** in section A1700. Marking this section as a “1” indicates a new admission. Marking the section as a “2” indicates a reentry and the stay continues without a new admission date.

11. What information may be required for a Medicaid post-pay review?

- Copy of the Physician Admission Orders.
- Copy of the History and Physical Exam completed five days prior to admission or within 48 hours after admission for clients eligible for Medicaid on admission OR a copy of the current annual History and Physical Exam for individuals determined eligible for Medicaid after admission to the NF.
- Documentation that supports the Physician visit requirement since admission for a Medicaid client that has been in the nursing facility 12 months or less OR documentation that supports the Physician visit requirement for the past 12 months for Medicaid clients who have been a resident of the nursing facility for over 12 months.
- Documentation the Physician reviewed the client’s total plan of care, and signed/dated progress notes at each visit.
- Documentation of the Senior Care Option screening and approval completed prior to admission for Medicaid eligible clients, when skilled care ends for clients admitted on Medicare, or during the Medicaid Pending period for individuals who have applied for Medicaid.
- The admission PASRR Screen and determination.
- Documentation of Managed Care Disenrollment for Medicaid Managed Care Clients admitted to the Nursing Facility.