PRIOR AUHTORIZATION/MDS ASSESSMENT QUESTIONS AND ANSWERS

1. **Are there still services that require a prior authorization?**

    a. NF Providers that are located outside of the State of Nebraska;
    b. 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
    c. Rural Hospitals requesting Swing Bed hospital care.

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

    a. Yes, SCO screening is required by the Nebraska Medicaid regulation that each individual age 65+ who is requesting Medicaid funding of nursing facility services be referred to SCO.
    b. Form MC9-NF is no longer used by SCO staff for prior authorization of nursing facility services. Instead, each Area Agency on Aging will provide written verification on agency letterhead.
    c. 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.

3. **What are the Nebraska Medicaid Minimum Data Set (MDS) requirements?**

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

4. **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?**

    Nebraska Medicaid does not reverse notification of the Medicare End Date except as a part of the MDS assessment. However, providers must ensure they follow Medicare requirements regarding documenting notification of Medicare Begin and End dates.

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

   If a claim adjustment is request 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 at http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-03.pdf

6. **In a case where the patient has a different date of birth (DOB), 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 payments. If the correct DOB 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 DOB in the system, please contact AccessNebraska at www.ACCESSNebraska.ne.gov or over the phone at 800-3883-4278 in order to confirm or correct the DOB for the resident. If the correct DOB is in the Medicaid eligibility system, the assessment will need to be modified by the nursing facility.

7. **What is the difference between an entry and re-entry?**

   An entry is when a person is newly admitted to a nursing facility, whereas a re-entry is when a resident enters a facility after a hospital stay to a bed that was held for the resident. Verify if the tracking form submitted indicates a re-entry or new admission in section A1700. Marking the section as a "2" indicates a re-entry and the stay continues without a new admission date. Marking this section as a "1" indicates a new admission.

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

   a. Copy of the Physician Admission Orders.
   b. 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.
   c. Documentation that supports the Physician visit requirement since admission for a Medicaid client that has been in the nursing facility 12 months or fewer 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 more than 12 months.
   d. Documentation the Physician reviewed the client's total plan of care, and signed/dated progress notes at each visit.
   e. Documentation of the SCO 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.

f. The admission PASRR Screen and determination.
g. Documentation of Managed Care Disenrollment for Medicaid Managed Care Clients admitted to the Nursing Facility.