GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal No: 15-23**

TO: DC Medicaid Providers

FROM: Claudia Schlosberg, JD
Senior Deputy Director/State Medicaid Director

DATE: July 15, 2015

SUBJECT: **UPDATED:** Nursing Facility Placement Procedures

This transmittal serves three purposes:

1. To clarify the guidelines for District of Columbia (DC) nursing facility admission.
2. To clarify the guidelines for out-of-state nursing facility placement.
3. To clarify the guidelines for continued stay reviews in DC, out-of-state, and bordering county nursing facilities.

Nursing Home Placement – DC: Initial Request

Approval for nursing home admission to a DC facility requires a completed Level of Care (LOC), Department of Health Care Finance (DHCF) Form-1728 and a Level I Pre-admission Screen Resident Review (PASRR). The completed LOC must be submitted to the Quality Improvement Organization (QIO) via the web-portal at www.qualishealth.org. The QIO will render a decision within 3 business days of receiving the LOC.

Nursing Home Placement Out-of-State and Bordering County:

To obtain approval for Out-of-State Nursing Facility admission, the nine (9) documents listed below must be completed. All documents must be submitted to the QIO via the web portal at www.qualishealth.org. The QIO will ensure that all required documents are received. A decision within 3 business days will be made. All approvals will receive a Prior Authorization (PA) number for a period of one (1) year, from the QIO. If the beneficiary does not meet nursing home LOC or documents are missing, a denial letter from the QIO will be generated and sent to the address provided.

Required Documents for Out-of-State Nursing Facility placement:

1. Cover page for Request for Out-of -State Nursing Facility Placement;
2. Request for Out-of-State Placement;
3. Proof of contact of In-State Nursing Facilities (a minimum of two (2) DC Nursing facilities must be contacted and deny placement);
4. A copy of the Level of Care approval letter from the QIO;
5. A copy of the Request for Medicaid Nursing Facility Level of Care (LOC), DHCF Form-1728;
6. A copy of the Pre-Admission Screening and Resident Review (PASRR);
7. Beneficiary Agreement;
8. A copy of the beneficiary's history and physical, and the discharge summary, if completed; and
9. If the beneficiary requires specialized care (such as tracheostomy, dialysis, etc.), submit a copy of the most recent physician order(s) and/or note(s).

Continued Stay Reviews -DC Nursing Facilities:

1. The QIO will complete an onsite LOC validation within 30 days of admission to the Nursing Facility. Six (6) months after admission and annually, the QIO will complete an onsite review. The onsite review will consist of the following verifications:
2. Signed physician certification every 60 days, for continued nursing home level of care; Minimum Data Sets (MDS) validation;
3. Review of the medical record and MDS flags to identify changes in the resident's medical condition and any quality of care concerns;
4. Evaluation of the potential for the recipient to receive alternative resources available in a home or community-based setting; and
5. PASRR screening, if needed.

Continued Stay Reviews -Out of State Nursing Facilities:

Approval for continued stay in an out-of-state nursing facility requires the submission of an annual LOC DHCF-1728 form to the QIO (one month prior to the expiration of the current Prior Authorization). The LOC can be submitted to the QIO via the web portal www.qualishealth.org. If the resident's behavioral/cognitive condition changes, a PASRR will be required. The QIO will render an LOC decision within 3 business days. All approvals will receive a Prior Authorization (PA) number for a period of one (1) year, from the QIO.

Continued Stay Reviews - Bordering County:

For continued stay approval, please submit Level of Care (LOC) DHCF Form-1728 to the QIO via the web portal prior to the end of the current Prior Authorization (PA). Within the year, the QIO will complete an onsite continued stay review. The onsite review will consist of the following verifications:

1. Signed physician certification every 60 days, for continued nursing home level of care;
2. Minimum Data Sets (MDS) validation;
3. Review of the medical record and MDS flags to identify changes in the resident's medical condition and any quality of care concerns;
4. Evaluation of the potential for the recipient to receive alternative resources available in a home or community-based setting; and
5. PASRR screening, if needed.

If you have any questions about this transmittal, please contact Cavella Bishop, Program Manager, Division of Clinician, Pharmacy, and Acute Provider Services at (202)724-8936, or via email at cavella.bishop@dc.gov; or Pamela Hodge, Management Analyst at (202)-442-4622 or via email at pamela.hodge@dc.gov.

Government of the District of Columbia
Department of Health Care Finance

Out-of-State Nursing Facility Placement Cover Page

Please print clearly and complete all sections

SECTION A: BENEFICIARY

Date:	Last Name:	First:	M.I.:	Medicaid ID:	Birth date:	Gender: ❑ M ❑ F

SECTION B: REQUESTING FACILITY

Facility Name:	Street Address:	City:	ST:	ZIP:

Phone:	Fax:	Name of Person Completing Form:

Title :

SECTION C: PLACEMENT FACILITY*

Facility Name:	Street Address:	City:	ST:	ZIP:

Phone:	Fax:

**If different than requesting facility*

SECTION D: PLACEMENT RATIONALE

Reason beneficiary is not being placed in the community. Check all that apply:

- ❑ Type or intensity of care required not available in the community
- ❑ Beneficiary prefers to receive care in a nursing facility
- ❑ Housing issues preclude individual from placement in the community
- ❑ Other: _____

SECTION E: APPLICATION CHECKLIST

- Request for Out-of-State Nursing Facility Placement Cover Page ❑
- Request for Out-of-State Placement Form ❑
- Proof of Contact of In-State Nursing Facilities ❑
  (a minimum of two (2) DC facilities must be contacted and deny placement)
- Level of Care approval from the Quality Improvement Organization (Delmarva) ❑
- Request for Medicaid Nursing Facility Level of Care (DHCF Form 1728) ❑
- Pre-Admission Screen/Resident Review for Serious Mental Illness and Intellectual Disability or Related Condition ❑
- Beneficiary Agreement ❑
- Beneficiary's history and physical ❑
- Discharge summary (if available) ❑ ❑ NA
- Copy of the most recent physician and nurse notes (as needed) ❑ ❑ NA

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Revised: June 1, 2015

Government of the District of Columbia
Department of Health Care Finance

Out-of-State Nursing Facility Placement

BENEFICIARY						
Date:	Last Name: First: M.I.:			Medicaid ID:	Medicare ID:	Gender: ☐ M ☐ F
SSN:	Permanent street address:	City:	ST:	ZIP:	Phone:	
Reason(s) placement requested:						
Diagnosis:						
Prognosis:						

REQUIRED TREATMENT AND FREQUENCY*	Daily	Weekly	Bi-weekly	Monthly
Behavioral Modification	☐	☐	☐	☐
Occupational Therapy	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐
Respiratory Care	☐	☐	☐	☐
Speech/Hearing	☐	☐	☐	☐

**Check all that apply*

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Revised June 1, 2015

Government of the District of Columbia

Level I Pre-Admission Screen/Resident Review for SMI, ID or Related Conditions

BENEFICIARY INFORMATION

Last Name:	First:	M.I.:	Gender: ❑ M ❑ F	Medicaid ID:	Social Security Number:
Date of Birth:	Assessment Type: ❑ Preadmission ❑ Significant Physical Change ❑ Significant Mental Change ❑ Suspicion of SMI or ID				

LEGAL STATUS

❑ Commitment ❑ Legal Guardian-Conservator ❑ Legal Representative/POA		Location: ❑ Home ❑ Hospital ❑ Nursing Facility ❑ Other	
Applicant agrees to legal guardian and/or family participation? ❑ Yes ❑ No	Interpreter Required? ❑ Yes ❑ No ❑ Spanish ❑ Amharic ❑ Chinese ❑ Korean ❑ Other	Interpreter Name:	
Legal Guardian/Family Member:		Street Address:	
Telephone:	City:	ST:	ZIP Code:
Power of Attorney:		Street Address:	
Telephone:	City:	ST:	Zip Code:

SECTION A: EXEMPTING CRITERIA▪

Beneficiary admitted to nursing facility directly from hospital after receiving acute inpatient care? ❑ Yes ❑ No
Beneficiary requires nursing facility services for the condition he/she received acute inpatient care? ❑ Yes ❑ No
Attending physician certifies beneficiary is likely to require less than 30 days nursing facility services? ❑ Yes ❑ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Name:	SIGN HERE	Date:
Title:		

▪*Further completion of this form IS NOT NECESSARY if the beneficiary meets all of the exemptions listed in Section A. If exempting criteria is not met, proceed to Section B. Beneficiary is being admitted under the 30-day hospital discharge exemption. If the beneficiary's length of stay exceeds 30 days , the Level II evaluation must be completed no later than the 40th day of admission, on or before the date:*

SECTION B: EVALUATION CRITERIA FOR SERIOUS MENTAL ILLNESS (SMI)♦

1. Does the beneficiary have a known diagnosis of a major mental disorder? If yes, list diagnosis and DSM Code_____ ❑ Yes ❑ No ❑ Unknown
2. Does the beneficiary have a diagnosis or evidence of a major mental illness limited to the following disorders: schizophrenia, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; Somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to chronic disability? ❑ Yes ❑ No ❑ Unknown. Specify diagnosis based on DSM-5 or current ICD criteria. ➔
3. Does the beneficiary have a history of any substance-related disorder diagnosis? ❑ Yes ❑ No ❑ Unknown Specify diagnosis ➔
4.

SMI Determination Based Upon: ❑ Documented History ❑ Behavioral Observation ❑ Medications ❑ Individual/Legal Guardian/Family Report

♦*The beneficiary is considered to have a positive serious mental illness (SMI) if (1) questions 1 or 2 in Section B are answered "Yes".* With a positive screen for SMI the beneficiary must be referred to the District of Columbia Department of Behavioral Health for a Level II evaluation.

SECTION C: SYMPTOMS

1. Does the beneficiary have any current or historical significant impairment in functioning related to a suspected or known diagnosis of mental illness? ❑ Yes (❑ Current ❑ Past: When) ❑ No

   Check box preceding description if any subcategories below are applicable:

   ❑ ***Interpersonal functioning***. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationships and social isolation.

   ❑ ***Concentration, persistence, and pace***. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these task.

   ❑ ***Adaptation to change***. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions, agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, , self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability or requires intervention by mental health or judicial system.

2. Within the last two years has the beneficiary (check either and/or both if applicable).

   ❑ experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g., had inpatient psychiatric care: was referred to a mental health crisis/screening center; has attended partial care/hospitalization; or has received Program of Assertive Community Treatment (PACT) or integrated Case Management Services); and/or:

   ❑ due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community, or intervention by housing or law enforcement officials?

   Narrative information including dates: _____

   _____

   _____

   _____

   _____

   The beneficiary's behaviors/symptoms are stable and not presenting a risk to self or others? ❑ Yes ❑ No

If questions 1 and 2 In Section B are checked "No", but question 1 in Section C is "Yes" and a box is checked in question 2, the Level 1 form must be sent to the District of Columbia Department of Behavioral Health to determine if a Level II evaluation is needed.

SECTION D: INTELLECTUAL DISABILITY** (ID) RELATED CONDITIONS (RC)

1. Beneficiary has diagnosis of ID? ❑ Yes ❑ No
2. Beneficiary diagnosed with ID prior to age 18? ❑ Yes ❑ No
3. Presenting evidence (cognitive or behavior functions) indicating beneficiary has ID or related condition that has not been diagnosed? ❑ Yes ❑ No
4. Referred beneficiary deemed eligible for services by an agency which serves individuals with ID or related condition? ❑ Yes ❑ No
5. Does the beneficiary have a current diagnosis, history or evidence of a related condition that may include a severe, chronic disability that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior? ❑ Yes ❑ No
   Condition: ❑ autism ❑ seizure disorder ❑ cerebral palsy❑ spina bifida ❑ fetal alcohol syndrome ❑ muscular dystrophy ❑ deaf ❑ blindness ❑ closed head injury
   Impairment: ❑ mobility ❑ self-care ❑ self-direction ❑ learning ❑ understanding/use of language ❑ capacity for independent living)

   Was the date of onset prior to age 22? ❑ Yes ❑ No If yes, explain:

   _____

   _____

6. Is the beneficiary considered to have ID or a Related Condition? ❑ Yes ❑ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Name:	SIGN HERE	Date:
Title:		

***Beneficiary is considered to have a positive screen for or a related condition if one of more the above questions in this section are answered yes. As a result, beneficiary must be referred to the District of Columbia Department on Disability Services for a Level II evaluation. If all of the questions are answered no, the beneficiary has a negative screen for ID or a related condition.*

SECTION E: DEMENTIA*

- ❑ The beneficiary has a diagnosis of dementia (including Alzheimer's disease or related disorder) based on criteria in the DSM-5 or current version of the ICD. (If checked specify DSM-5 or ICD codes:_____
- ❑ The following criteria were used to establish the basis for a dementia diagnosis: ❑ Mental Status Exam ❑ Neurological ❑ History Symptoms ❑ Other Diagnostics (specify):_____
- ❑ The physician documented dementia as the primary diagnosis **OR** that dementia is more progressed than a co-occurring mental illness diagnosis. Explain documentation and verification: _____

**A primary diagnosis of dementia, including Alzheimers' disease or related disorder IS NOT considered a major mental illness. Dementia applies to beneficiaries with a confirmed diagnosis of dementia that has been documented as a primary diagnosis more progressed than a co-occurring mental illness. If there is no confirmed diagnosis of dementia, check* N/A❑. *Only if the boxes in front of ALL THREE statements above are checked is the beneficiary designated as having a primary mental illness dementia exclusion. If none of the statements above are checked, then the beneficiary is not designated as having a primary mental illness dementia exclusion.*

SECTION F: ADVANCE GROUP DETERMINATION°

1. Is the beneficiary being admitted for convalescent care not to exceed 120 days due to an acute physical illness which required hospitalization and does not meet all criteria for an exempt hospital discharge (described in Section A)? ❑ Yes ❑ No
2. Does the beneficiary have a terminal illness (life expectancy of less than six months) as certified by a physician? ❑ Yes ❑ No
3 Does the beneficiary have a severe physical illness, such as coma, ventilator dependence, functioning at a brain stem level or other diagnoses which result in a level of impairment so severe that the beneficiary could not be expected to benefit from specialized services? ❑ Yes ❑ No
3. Is this beneficiary being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days. ❑ Yes ❑ No
4. Provisional Delirium: The presence of delirium in people with known or suspected MI and/or ID precludes the ability to make an accurate diagnosis. The person's Level I Screen and LOC will be updated no greater than 7 calendar days following admission to the NF (a physician signed statement certifying the delirium state must accompany this screen).
5. Is the beneficiary being admitted for a stay not to exceed 14 days to provide respite? ❑ Yes ❑ No

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud

Print Name:	SIGN HERE	Date:

°*If the beneficiary is considered to have SMI, ID or RC, complete this section. Otherwise, skip this section and complete Section G. If any questions in this section are checked yes, there is no need for a Level II referral.* ↑

SECTION G: RESULTS OF SMI/ID (CHECK ALL THAT APPLY)

- ❑ Beneficiary has negative screen for serious mental illness and no further action is necessary.
- ❑ Beneficiary has negative screen for ID or related conditions and no further action is necessary.
- ❑ Beneficiary has a positive screen for serious mental illness and has been referred to DBH for a Level II evaluation. Date:
- ❑ Beneficiary has a possible positive screen and the Level 1 form has been forwarded to DBH for review. Date:
- ❑ Beneficiary has a positive screen for intellectual disability and has been referred to DDS for a Level II evaluation. Date:
- ❑ Notice of referral for Level II, if applicable, distributed to Beneficiary/Representative Date :

Government of the District of Columbia

Level I Pre-Admission Screen/Resident Review for SMI, ID or Related Conditions

I certify the information in this section is accurate to the best of my knowledge and understand that knowingly submitting inaccurate, incomplete, or misleading information constitutes Medicaid fraud		
Print Name:	SIGN HERE	Date:

The District of Columbia Department on Disability Services is the contact agency for a **Level II** evaluation:

Shirley Quarles-Owens, RN MSN
Supervisory Community Health Nurse
DC Department on Disability Services
Developmental Disabilities Administration
Health and Wellness Unit
1125 15th Street, NW, 8th Floor
Washington, DC 20005
202-730-1708 (office)
202-730-1841 (fax)
202-615-8268 (mobile)
shirley.quarles-owens@dc.gov

The District of Columbia Department of Behavioral Health is the contact agency for **Level II** evaluations:

Chaka A. Curtis, RN
Psychiatric Nurse / PASRR Coordinator
Division of Integrated Care
DC Department of Behavioral Health
64 New York Ave NE - Room 310
Washington, DC 20002
202-673-6450 (office)
202-671-2972 (fax)
202-439-1143 (mobile)
chaka.curtis@dc.gov

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Government of the District of Columbia
Department of Health Care Finance

Proof-of-Contact In-State Nursing Facility

SECTION A: BENEFICIARY FOR WHOM OUT-OF STATE PLACEMENT SOUGHT			
Last Name:	First:	MI:	Date of Request:

SECTION B: NURSING FACILITIES			
Facility Name 1:	Person Contacted:	Date Contacted:	Admission Approved? ❑ Yes ❑ No
Comments:			
Facility Name 2:	Person Contacted:	Date Contacted:	Admission Approved? ❑ Yes ❑ No
Comments:			

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Revised June 1, 2015

Government of the District of Columbia
Department of Health Care Finance

Nursing Facility Level of Care
Form 1728

SECTION A: BENEFICIARY

Last Name:	First:	MI:	Medicaid ID:	SSN:	Birth date:	Gender: ❑ M ❑ F

Permanent Street Address:	City:	ST:	ZIP:	Phone:

Present Location of Beneficiary (if different than above):	Date of Request:

SECTION B: LEVEL OF CARE

❑ Nursing Facility	❑ Adult Day Treatment	❑ Elderly & Individuals w/Physical Disabilities (EPD) Waiver
	Reason	
❑ Return from hospital after Medicaid bed-hold expired* ❑ Transfer from EPD Waiver to NF ❑ Annual reassessment ❑ Initial NF placement ❑ Conversion from other payor source to Medicaid. Start: _____ ❑ Transfer from NF	❑ Initial assessment	❑ Initial assessment ❑ Annual reassessment ❑ Transfer from NF to EPD Waiver

**If Medicaid bed-hold days <18 days no level of care required*

SECTION C: LEGAL REPRESENTATIVE ❑ POA ❑ LEGAL GUARDIAN ❑ NA

Name:	Street Address:	City:	ST:	ZIP:

SECTION D: BENEFICIARY FUNCTIONAL STATUS

Activities	**Independent** (needs no help)	**Supervision or Limited Assistance** (needs oversight, encouragement or cueing or highly involved, but requiring assistance)	**Extensive Assistance or Totally Dependent** (may help, but cannot perform w/o help from staff or cannot do for self at all)
ADLs:			
Bathing	❑	❑	❑
Dressing	❑	❑	❑
Overall Mobility	❑	❑	❑
Eating	❑	❑	❑
Toilet Use	❑	❑	❑
IADLs:			
Medication Management	❑	❑	❑
Meal Preparation	❑	❑	❑
Housekeeping	❑	❑	❑
Money Management	❑	❑	❑
Using Telephone	❑	❑	❑

Beneficiary ventilator dependent? ❑ Yes ❑ No	List additional supporting documents here:

Name of Person Completing Form:	Title:	Phone:	Date:
Signature:			

SECTION E: CLINICIAN ATTESTATIONS & AUTHORIZATIONS

❑ Physician ❑ Physician Assistant ❑Nurse Practitioner	Street Address:	City:	ST:	ZIP:

Phone:	NPI #:	Date:	Signature:

SECTION F: QUALITY IMPROVEMENT ORGANIZATION AUTHORIZATIONS

Level of Care: ❑ Nursing Facility ❑Adult Day Treatment ❑ EPD Waiver	Certification Period (for EPD only):	Date:

Authorized Signature:	Comments:

Upload this form via the Qualis Health Provider Portal at www.qualishealth.org. In the Healthcare Professional Drop-Down Menu: Select DC Medicaid-> Provider Resources-> Qualis Health Provider Portal. You may obtain assistance in registering for the Qualis Health Provider Portal by contacting providerportalhelp@qualishealth.org

Revised May 20, 2015

Government of the District of Columbia
Department of Health Care Finance

Beneficiary Agreement for Nursing Facility Placement

Last Name:	First:	MI:
Person responsible for making decisions on beneficiary's behalf:		

- ❑ I agree to out-of state nursing facility placement
- ❑ I understand DC Medicaid benefits end with my death
- ❑ I understand DC Medicaid does not pay for funeral or burial expenses
- ❑ I understand I may be eligible to receive care in the community and choose to receive care in a nursing facility

Signature:	Date:

Upload this form via the Qualis Health Provider Portal at www.qualishealth.org. In the Healthcare Professional Drop-Down Menu select DC Medicaid-> Provider Resources-> Qualis Health Provider Portal. You may obtain assistance in registering for the Qualis Health Provider Portal by contacting providerportalhelp@qualishealth.org

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