GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal # 17-09**

TO: DC Medicaid Providers

FROM: Claudia Schlosberg, J.D.
Senior Deputy Director and State Medicaid Director

DATE: April 20, 2017

SUBJECT: **UPDATE: Out-of-State Nursing Facility Placement and Review Procedures**

Effective May 1, 2017, the Form 1728 Level of Care (LOC) will be discontinued and a new process will be immediately implemented. This transmittal serves two (2) purposes:

1. To introduce new guidelines for out-of-state (OOS) nursing facility placements
2. To introduce new guidelines for OOS continued stay reviews.

Nursing Home Admission Approval for Out-of-State Placement
With the discontinuance of Form 1728, the Department of Health Care Finance (DHCF) will introduce a new process that will become effective on May 1, 2017.

a. The original provider (hospital, nursing home, physician's office, etc.) shall submit a signed Prescription Order Form (POF) and completed Pre-Admission Screening and Resident Review (PASRR) to Delmarva requesting a level of need face-to-face assessment.

b. Delmarva will visit the beneficiary's location and conduct a face-to-face assessment within 48 hours for hospital discharges, or within five (5) calendar days for community-to-nursing facility transitions.

c. After the assessment has been completed, Delmarva will complete a determination sheet which will reflect the recommendations. The determination sheet and an approval or denial letter will be issued by Delmarva within forty-eight (48) hours of the assessment.

d. If Delmarva determines that the beneficiary is appropriate for nursing home placement, the OOS facility can proceed with the placement process.

Nursing Home Out-of-State Placement Process

To obtain approval for admission into an out-of-state nursing facility, each of the nine (9) documents listed below must be completed.

a. All documents must be submitted to the District of Columbia's Quality Improvement Organization (QIO) via the web portal at www.qualishealth.org. The QIO will ensure that all required documents are received and a decision will be rendered within three (3) business days.

b. The QIO will provide a Prior Authorization (PA) number, effective for a period of one (1) year for all approvals. If documents are missing or there is an available District nursing home bed available, 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 each request for an 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 the subsequent denial for placement];
4. A copy of the Determination Sheet from Delmarva;
5. A copy of the level of need approval letter from Delmarva;
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 for DC Nursing Facilities

The QIO will complete an onsite level of need and PASRR validation within thirty (30) days of admission to the nursing facility.

Six (6) months after admission and annually, the QIO will complete an onsite review. It is important that the nursing facility submit a monthly census to the Long Term Care Administration at DHCF.

The onsite review will consist of the following verifications:

a. Signed physician certification every sixty (60) days, for continued nursing home level of care;
b. Minimum Data Set (MDS) validation;

c. Review of the medical record and MDS flags to identify changes in the resident's medical condition and any quality of care concerns;
d. Evaluation of the potential for the beneficiary to receive alternative resources available in a home or community-based setting; and
e. PASRR screening, if needed.

If you have any questions about this transmittal, please contact Ieisha Gray, Director, Long Term Care Administration at (202) 442-5818, or via email at ieisha.gray@dc.gov.

Enclosure:
Prescription Order Form (POF)

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE

PRESCRIPTION ORDER FORM (POF) GUIDE

This cover sheet provides guidance to physicians and advanced practice registered nurses (APRNs) on how to complete the attached Prescription Order Form (POF), which is required by the District of Columbia's Department of Health Care Finance (DHCF) to receive Medicaid-funded long term care services and supports.

Section I: Patient Information

This section provides information on the individual seeking Medicaid-funded long term care services and supports. The following is REQUIRED for the Department of Health Care Finance to process this form:

- Patient DC Medicaid Number (*8 digits*)
- Name (*First, Last*)
- Date of Birth
- Telephone Number

If there are special instructions for contacting this patient, please include these in this section.

Section II: Physician/APRN Information

This section provides information on the physician/APRN ordering Medicaid-funded long term care services and supports for the individual referenced in Section 1. Please note that all referring providers must be enrolled as a DC Medicaid Provider. DHCF has a streamlined application process for ordering/referring providers, which can be obtained at https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/10327. Please note that providers who enroll as ordering/referring providers only will not receive payment for any claims submitted, and will not be part of the Medicaid-eligible providers' directory.

The following is REQUIRED for the Department of Health Care Finance to process this form:

- Provider Name (*First, Last*)
- DC Medicaid Provider Number (*8 digits*)
- Telephone Number

Section III: Determining Need for Services

This section provides information on the individual's need for long term care services and supports, which include:

- case management,
- personal care aide,
- homemaker,
- chore aide,
- personal emergency response,
- assisted living,
- **occupational therapy (need MD signature),**
- **physical therapy (need MD signature),**
- adult day health,
- environmental accessibility adaptation, and
- nursing home.

Parts A and B of this section are REQUIRED for the DHCF to process this form. Part C allows the provider to note any changes in the patient's medical condition. Part D allows the provider to detail the reason for the referral (e.g., patient is being discharged and needs assistance at home, patient could benefit from day activities, etc.). **Note: Occupational and physical therapy must be ordered by a doctor.**

The ordering physician/APRN's signature on this POF certifies the individual's need for long term care services and supports.

Please ensure that all mandatory fields noted with ** are filled out—this will prevent delays in your patient's connection to services. The completed form must be faxed to the Delmarva Foundation at 202-698-2075.

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE

PRESCRIPTION ORDER FORM (POF)

FOR LONG TERM CARE SERVICES AND SUPPORTS

This completed form must be faxed to the Delmarva Foundation at 202-698-2075.

SECTION I: PATIENT INFORMATION

A. **PATIENT D.C. MEDICAID NUMBER (*8 digits*)	B. **NAME (*LAST, FIRST*)	C. **DATE OF BIRTH: _____/_____/_____
DI. **TELEPHONE NUMBER _____-_____-_____ DII. SECONDARY TELEPHONE NUMBER _____-_____-_____		E. CURRENT ADDRESS
FI. EMERGENCY CONTACT, NAME _____ FII. TELEPHONE NUMBER _____-_____-_____		G. PERMANENT ADDRESS (If different than above)
SPECIAL INSTRUCTIONS		

SECTION II: PHYSICIAN/APRN INFORMATION

A. **PROVIDER NAME (*LAST, FIRST*)	B. **DC MEDICAID PROVIDER NUMBER (*8 digits*)
C. **TELEPHONE NUMBER _____-_____-_____	D. NATIONAL PROVIDER IDENTIFIER NUMBER
E. PROVIDER ADDRESS	F. FAX NUMBER _____-_____-_____

SECTION III: DETERMINING NEED FOR SERVICES

A. **This patient has the following chronic medical condition(s)/ICD-10 diagnosis(es):	B. **This patient is unable to independently perform the following (*check all that apply*): ☐ Bathing ☐ Dressing ☐ Overall Mobility ☐ Eating ☐ Medication Management ☐ Using Telephone ☐ Housekeeping ☐ Meal Preparation ☐ Toilet Use
C. This patient's condition has changed significantly, as follows:	D. The reason for this referral to services is:

I have personally examined this patient. Based upon my professional opinion, long term care services and supports are medically necessary.

**Signature of Ordering Physician/APRN: _____ Date: ____/____/____

**These fields are required for the Department of Health Care Finance to process this form.