MyCare Long Term Care (LTC) Nursing Facility FAQs

The nursing facility network is an essential part of the health care delivery system and we value your partnership. We appreciate the compassion you offer in delivering quality care to our members enrolled in CareSource® My Care Ohio (Medicare – Medicaid Plan).

We want to provide you with answers to frequently asked questions about the nursing facility benefit and Level of Care. Covered services for the nursing facility benefit are outlined in the grid at the end of this document.

When is Prior Authorization from CareSource required?

Prior Authorization for nursing facility care is required for the following services:

1. Skilled Nursing Care
2. Respite Care
3. Hospice Care
4. Part B Therapy services greater than 30 visits per therapy modality.
   Note: Effective 1/15/17, Part B therapies require a Prior Authorization after 30 visits.

How are requests Prior Authorization (PA) made?

Requests for skilled care, respite care, hospice care, and Part B Therapy after 30 visits must be submitted to CareSource Medical Management. Requests must be faxed to 1-888-752-0012.

What is the prior authorization process for Skilled Nursing Facility Admission?

Normally, the prior authorization will take place through the discharge planning process when post-acute care needs are identified. The CareSource Medical Management Department will be in direct contact with the acute inpatient facility or skilled nursing facility to assist with ensuring medically necessary nursing facility admissions occur in a timely manner. In the event an admission to a nursing facility occurs after normal business hours, CareSource will accept the notification from the nursing facility and review the admission information on the next business day to evaluate for skilled coverage.

Who is responsible for requesting prior authorization Skilled Nursing Facility services?

The nursing facility is responsible for the prior authorization for skilled services. Skilled services are authorized based on medical necessity but do not require a 3 day qualifying hospital stay if the member's Medicare benefits are also being managed under the CareSource MyCare benefit. Hospital discharge planners can work with CareSource to help select a facility that is in network and can provide the required care to meet the member's skilled needs.

What is the process for Custodial (or long term care) Nursing Facility Stay Authorizations?

Prior Authorization for Long Term Care is NOT required for room and board services. CareSource continues to complete NF Level of Care as appropriate.

What is a Level of Care (LOC)?

A nursing facility –based level of care is one in which and individual requires assistance with two activities of daily living (ADLs), at minimum, or completion of one ADL and assistance with medication administration OR a minimum of one skilled nursing or skilled rehabilitation service OR twenty four hour support to prevent harm due to cognitive impairment (Source: OAC 5160-3-08 A, B, C and D).

What information must be submitted to determine a Level of Care?

The following information is needed to identify and support the individuals need for nursing facility based care:

1. 7000 Form or Preadmission Screening & Resident Review (PASRR) Screen
2. Level II Review Results, if applicable
3. Resident Review Results or Preadmission Screening Identification (PAS ID)
4. Clinical Information including Diagnosis, Medications, MDS Section G or other information that supports the individuals ADL function, Recent History and Physical
5. Other information as requested by the Clinical Reviewer

This information should be faxed to the MyCare Transition Coordinators at the time of the LOC request submission to allow for timely response to be returned. LOC determination results will be returned as soon as possible but no later than 7 business days from the time of request pending the submission of the required information. The MyCare Transition Coordinators will notify the requestor if there is a need for additional information to process the Level of Care request.

When is a Level of Care required?

A Level of Care (LOC) is necessary when a member is admitted to a nursing facility and CareSource MyCare will be paying for long term care services. The Level of Care is a document that references the specific rule in the Ohio Administrative Code (OAC) that supports the individual requiring care in a nursing home. A LOC is required in the following situations:

1. For a member who is admitted to a nursing facility in which CareSource MyCare will pay for long term room and board services.

2. When a member moves from one long term care facility to another for long term care.
3. When a member who had been on hospice care, revokes the hospice benefit, or is discharged from hospice and returns to intermediate care.

4. When a member exhausts the allotted 30 bed hold days in a calendar year. If this occurs, every time a member leaves the facility (i.e. hospitalization or other LOA) a new request for a LOC must be submitted to the MyCare Transition Coordinators.

How long is a Level of Care valid?

A level of care is valid for as long as a member remains in the same facility, does not exhaust bed hold days, and does not have a change in condition. As already noted, a new Level of Care determination is needed if a member moves to a new facility, exhausts bed hold days, is discharged to the community and seeks readmission, or has a change in condition requiring a new LOC.

What occurs when a MyCare CareSource member moves from the demonstration area?

We recognize that members may move in and out of the demonstration area in which CareSource is participating for various reasons. The Transition Coordinators will review requests and issue (as appropriate) LOC determinations for members moving to a new facility outside of the demonstration area. However, it is advised that the new facility reach out to the Pre-Admission Review Office in their area to obtain a Level of Care determination as well. This may help to satisfy any LOC of requirement for the new payment source as the individual's coverage with CareSource may be impacted by the move to the new area.

Where do I find the Long Term Care Authorization number?

CareSource does not require Prior Authorization for Room and Board. The member must meet nursing facility level of care to qualify for Room and Board services.

What if a member needs Respite Care?

Respite stays require prior authorization through CareSource Medical Management.

What is the policy for Bed Hold days?

Medicare does not reimburse for leaves of absence from a facility. CareSource MyCare Medicaid benefits will reimburse up to 30 Bed Hold days per calendar year. Member who exhaust the 30 bed hold days within a calendar year will require a new Level of Care (LOC) determination. Requests for LOC must be faxed to 1-888-752-0012, Attention: MyCare Transition Coordinator. Please work with the member's assigned Care Manager regarding any needs over 30 days per year.

What happens when the member exhausts their 100 day Medicare Skilled nursing benefit?

For a member that does not have CareSource for their Medicare coverage, the member's Medicare plan will issue the Notice of Medicare Non-Coverage (NOMNC). CareSource will issue the NOMNC for members enrolled in CareSource MyCare Ohio for both Medicaid and Medicare. After 100 days of Medicare coverage, CareSource will evaluate the continued need for continued services, both skilled and non-skilled, under Medicaid.

How will Care Management interventions be addressed?

The Care Manager will provide care coordination and development of a care plan that includes a trans-disciplinary team approach. Members of the team will include the member and his/her physician as well as the nursing facility staff, family members, caregivers, physicians and other providers that the member would like involved. The care plan contains goals and interventions that are designed to maximize the member's level of support and wellness. Collaboration with all the team members and the member to assess level of care, which will include face to face assessment, will be coordinated with the nursing facility's care management designee. The member's Care Manager will work with your nursing facility to develop trans-disciplinary team meetings, coordinate ongoing visits with the member, and establish any additional supports for the member needs.

Services	CareSource Medicare-Medicaid	CareSource Medicaid only	CareSource Contact Information
Bed Hold Days	30 days per calendar year under Medicaid benefit; No Prior Authorization; Notification to CM > 30 days. New LOC is required.	30 days per calendar year under Medicaid benefit; No Prior Authorization; Notification to CM > 30 days. New LOC is required.	CM contact number; MyCare Transition Coordinator for LOC request
Hospice	Room & Board covered under Medicaid benefit; Hospice must notify CareSource Medical Management of facility.	Room & Board covered under Medicaid benefit; Hospice must notify CareSource Medical Management of facility.	1-800-488-0134
Readmission from acute hospital to skilled facility	PA required; 3-day hospital stay requirement waived. LOC may be needed due to change in condition or care needs.	Seek authorization from the member's Medicare provider. After 100 days of Medicare skilled benefit, CareSource will review for Medicaid benefit. LOC may be needed due to change in condition or care needs.	1-937-487-0152; MyCare Transition Coordinator for LOC request
Readmission from acute hospital to non-skilled facility (room & board)	Continue with established Medicaid authorization for a 1 year period from the member's eligibility; Notify CM of the room & board readmission. LOC is required if bed hold days have been exhausted.	Continue with established Medicaid authorization for a 1 year period from the member's eligibility; Notify CM of the room & board readmission. LOC is required if bed hold days have been exhausted.	CM contact number; MyCare Transition Coordinator for LOC request
New admission - skilled facility	PA required; 3 -day hospital stay requirement waived. LOC is required.	Seek authorization from the member's Medicare provider. After 100 days of Medicare skilled benefit, CareSource will review for Medicaid benefit. LOC is required.	Medical Management; MyCare Transition Coordinator for LOC request

Services	CareSource Medicare-Medicaid	CareSource Medicaid only	CareSource Contact Information
New admission – non-skilled facility (room & board)	Notify CM of the room & board readmission. LOC is required.	Notify CM of the room & board readmission. LOC is required.	
Change from skilled to non-skilled	Notify the CM; CM will complete an assessment. LOC is required.	Notify the CM; CM will complete an assessment. LOC is required.	
Admission from non-skilled to skilled admission	PA required; 3 -day hospital stay requirement waived. LOC is required.	Seek authorization from the member's Medicare provider. After 100 days of Medicare skilled benefit, CareSource will review for Medicaid benefit. LOC is required.	
Ancillary Services	PA required.	Verify eligibility with the member's Medicare plan. Medicaid primary services may require PA. Refer to the PA list in the MyCare Provider Manual.	
Part B therapies	PA required as indicated above.	Follow the Medicaid benefits.	1-800-488-0134

PA = Prior Authorization MM = Medical Management CM = Care Manager LOC = Level of Care