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03.10 INTRODUCTION

Level of Care determination is the process of identifying the extent of a person's medical, psycho-behavioral and functional disability in keeping with the South Carolina Level of Care Criteria for Medicaid-Sponsored Long Term Care. By applying these criteria, an applicant's requirement for skilled or intermediate care can be determined.

03.20 LEVEL OF CARE POLICIES AND PROCEDURES

03.21 The Level of Care Determination Process

Following Intake and case assignment, the CLTC **Nurse Consultant** evaluates the applicant's assessment form. To clarify the assessment information, the **Nurse Consultant** may consult with the applicant and/or primary contact, physician, hospital/nursing home assessor, and Nurse Consultant team member with regard to medical, psycho-behavioral and functional information. A completed assessment is required to determine level of care**.** The **Nurse Consultant** may complete the assessment by conducting a face to face visit or by a telephone interview. If the assessment information is not clearly obtained or the information is questionable, a face-to face visit is required. If the Level of Care is not clearly Intermediate or Skilled or the accuracy of the information is questionable, a face-to-face visit and/or input from the Physician or knowledgeable other may be required. **The Nurse Consultant** may complete the assessment via telephone or a face-to-face visit. **Exception**: See Recertification Policy.

Once the CLTC **Nurse Consultant** determines that (s) he has adequate information to make a level of care decision, a **Nurse Consultant** team conference is held to discuss the case. In order to make a level of care decision, the Assessment must be completed in Phoenix. (Refer to Policy 02.28 Medical Information Completion for information concerning sources of information). The recommended level of care in Phoenix is considered during the team conference. A final level of care is determined from the team conference and assigned in accordance with the South Carolina Level of Care Criteria for Medicaid-sponsored Long Term Care. If the level of care determined at the team conference is not what was recommended by Phoenix, the level of care must be reviewed by the Area Administrator or Lead Team. The third signature must be completed by the Area Administrator or Lead Team.

If the level of care is tentative, the **Nurse Consultant** annotates in the narrative. If no level of care is determined, the **Nurse Consultant** annotates the team conference and reason for inability to determine level of care in the narrative. If the team was unable to determine level of care or if the physician insists that the applicant requires long term care services, the team should confer with the **Area Administrator** and/or the **designated Lead Team**. The **Area Administrator** may recommend that the case be forwarded to Central Office for input/determination of the level of care. (See also 3.22 if the level of care appears to be Medically Ineligible.)

If Phoenix requires a third signature, the **Area Administrator** or **Lead Team** may sign. If the decision was made by Central Office, the **Central Office Designee**, **Area Administrator** or **Lead Team** may sign as the third signature once the **Nurse Consultant** has received notification of Level of Care Determination.

The level of care and the justification for the level of care determination must be properly documented by the **Nurse Consultant** in Phoenix. The **Nurse Consultant** should inform the applicant, primary contact, and the referral source, if appropriate, of the level of care using the CLTC Notification Form 171. The Regional Institutional Medicaid Eligibility Worker will be notified of the level of care through the Eligibility Workflow in Phoenix.

03.22 Medically Ineligible

If upon the assessment visit, an applicant appears to be medically ineligible, the **Nurse Consultant** will seek medical information from the physician by mailing or faxing the Physician's Input Letter and the CLTC Consent Form 121.

Evaluation of the medical information (See Section 02.28.10) obtained from the physician will ensure that the applicant is at the appropriate level of care and that the case record is complete for possible appeals proceedings.

Once an applicant has been determined to be medically ineligible, s/he is ineligible for CLTC services and for Medicaid-sponsored nursing home placement. However, determination of medical ineligibility does not mean that the applicant cannot be admitted to a long term care facility under some other payment source.

When an applicant has been determined to be medically ineligible, a Level of Care Certification Letter DHHS Form 185 for nursing home applicant, or a CLTC Notification Form 171, for community-based waivered services applicant, is used to formally notify the applicant and/or primary contact of this decision. This denial informs all individuals involved in the application process that the applicant is ineligible for Medicaid reimbursed skilled or intermediate care.

If the applicant appears to be medically ineligible at any time while the case is pending, a visit must be made to the applicant to re-determine the level of care. The case should be reviewed with the **designated Lead Team or Area Administrator** prior to rendering a final decision. If the **Area Administrator** determines the case requires further review, it should then be referred to the Central Office for a final level of care decision. Once the level of care is determined by Central Office, Central Office will notify the **Nurse Consultant** of the Level of Care Determination and the required third signature may be signed by **the Area Administrator, Lead Team or Central Office Designee.**

Special efforts should be made to discuss the level of care decision and possible alternatives with the applicant and/or primary contact. The **Nurse Consultant** should inform the applicant to contact CLTC if there is a change in his/her health status.

If the applicant's final level of care determination is medically ineligible, the team signs the final level of care in the Assessment level of care section of Phoenix. The **Nurse Consultant** terminates the program application in Phoenix and if appropriate also terminates the case. A CLTC Notification Form 171 or a Certification Letter DHHS Form 185 is prepared and forwarded along with the correspondence file to the **designated Support Staff** for mailing and/or faxing of paperwork as indicated, followed by appropriate filing of the correspondence file.

03.23 Timeliness Standard

From the point that the assessment information is complete and adequate to determine the level of care, the level of care must be determined , completed and documented **within three (3) business days.**

There may be times when clarification of an applicant's medical condition or additional information is indicated and may interfere with the established time frames. Any exceptions of these frames must be documented in the Narrative.

The initial level of care must be teamed conferenced by two **Nurse Consultants**. (For waiver participants, see also Chapter 5, 05.38.)

03.24 Level of Care Determination for Hospital-Based Applicants

For hospital-based applicants seeking nursing home admission or community-based services, the level of care determined by the **Nurse Consultant** team, prior to discharge, will be a tentative level of care. A visit with the applicant is required on the initial tentative level of care to secure or verify assessment information and obtain written choice for locus of care. This tentative level of care is especially helpful to hospital discharge planners/social workers, applicants, and/or primary contact as they pursue nursing home placement. The tentative level of care must be documented in the Narrative. The team's tentative level of care decision must be transmitted by the CLTC Notification Form 171 to the hospital discharge planner/social worker and applicant and/or primary contact. The **Nurse Consultant** instructs **the designated Support Staff** to send the form as indicated.

Once a tentative level of care has been established, the assessment information must be reviewed when nursing home placement is imminent to verify the applicant's status and condition.

The hospital discharge planner must call CLTC on the day of discharge to review the applicant's condition with a **Nurse Consultant**. If the condition of the applicant has not changed significantly since the tentative level of care was determined, the team can proceed with completing the Source of Information/Level of Care section

in Phoenix without additional assessment or discussions. This also applies if the applicant's functional status has not changed since the tentative level of care but Medicare skilled services have been decreased or discontinued. The tentative team conference Narrative must include the skilled service that qualified the applicant for Medicare and what the level of care would be if skilled service discontinued.

The final level of care must be conferenced by two **Nurse Consultants** if there has been a significant change (level of care change). The team member completes a dated signature for the level of care and the **Nurse Consultant** enters the completed level of care in Phoenix.

At discharge, a Level of Care Certification Letter, DHHS Form 185, will be completed by the **Nurse Consultant** and forwarded to the appropriate parties by the **Nurse Consultant** and/or **Support Staff**. It is the admitting nursing facility's responsibility to ensure that an applicant has a valid certification and a Level I PASARR Screening prior to or at the time of admission.

03.24.10 Medicare Referrals

Medicare hospital insurance can help pay for inpatient care in a Medicare-certified skilled nursing facility.

To qualify for Medicare-sponsored nursing home placement, the applicant must be eligible for Medicare/Part A benefits. **Note: Medicare numbers ending in the letter M do not have nursing home benefits.** The following must also be met:

- The beneficiary must be an inpatient of a hospital for a medically necessary stay for at least three (3) consecutive calendar days;
- Services must be needed for a condition which was treated during the applicant's qualifying hospital stay, or by a condition which arose while he/she was in the facility for treatment of a condition previously treated in the hospital;
- Applicant must be **admitted** to a participating skilled nursing facility **within thirty (30) calendar days** of discharge from an inpatient hospital stay where they must require and receive a **covered level of care**;
- Applicant requires skilled nursing services **or** skilled rehabilitation services;

- Applicant requires a single or combination of goal-directed therapy service five (5) days per week;

- Daily skilled services can be provided only on an inpatient basis in a skilled nursing facility; and,

- The services must also be reasonable and necessary for the treatment of an applicant's illness or injury and be furnished under order from a physician. The services must be reasonable in terms of duration and quantity.

Applicants who appear potentially eligible for extended care benefits should be identified and the hospital should be instructed via the CLTC Notification, to pursue Medicare reimbursement. A Certification Letter for Medicaid-sponsorship is not issued for Medicare cases.

03.24.20 Hospice Interaction with Nursing Facility Certification

If an applicant receives a Medicare qualifying skilled service for a condition unrelated to the terminal diagnosis, Medicare will pay the nursing facility and the hospice benefit.

If an applicant receives a Medicare qualifying skilled service for a condition related to the terminal diagnosis, Medicare will only pay the hospice benefit. In this situation, CLTC will certify for Medicaid if Medicaid criteria is met.

If the applicant is not Medicare eligible, certify as usual.

Quick Reference for Level of Care Checklist

Skilled Services (SKS)

SKS 1. Daily monitoring/observation and assessment due to an unstable medical condition which may include overall management and evaluation of a care plan which changes daily or several times a week.
SKS 2. Administration of medications which require frequent dosage adjustment, regulation, and monitoring.
SKS 3. Administration of parenteral medications and fluids which require frequent dosage adjustment, regulation, and monitoring. (Routine injection(s) scheduled daily or less frequently [such as insulin injection] do not qualify.)
SKS 4. Special catheter care (e.g., frequent irrigation, irrigation with special medications, frequent catheterizations for specific problems.)
SKS 5. Treatment of extensive decubitus ulcers or other widespread skin disorder. (Important considerations include: Signs of infections, full thickness tissue loss, or requirement of sterile technique)
SKS 6. A single goal-directed rehabilitative service (speech, physical, or occupational therapy) by a therapist 5 days per week. Combinations of therapies will satisfy this requirement.
SKS 7. Time-limited, goal-directed, educational services provided by professional or technical personnel to teach self-maintenance, such as education for newly-diagnosed or acute episodic conditions (e.g., medications, treatments, procedures).
SKS 8. Nasogastric tube or gastrostomy feedings.
SKS 9. Nasopharyngeal or tracheostomy aspirations or sterile tracheostomy care.
SKS 10. Administration of medical gases (e.g., oxygen) for the initial phase of condition requiring such treatment, monitoring, and evaluation (generally no longer than two week duration).
SKS 11. Daily skilled monitoring or observation for conditions that do not ordinarily require skilled care, but because of the combination of conditions, may result in special medical complications. In these situations, the complications and the skilled services required must be documented.
SKS 12. This individual is totally dependent in all activities of daily living: incapable of locomotion; unable to transfer; totally incontinent of urinary or bowel function; must be totally bathed and dressed and toileted and need extensive assistance to eat. (Also referred to as TC = total care.)

A person must need at least one of the numbered skilled services (Items 1-11, adapted from the Medicare requirements at 42 C.F.R. 409.32-35 [1993]) and have at least one of the numbered functional deficits listed below to qualify for skilled level of care. A person needing item #12 by itself qualifies for skilled level of care because this represents a total care individual. In order to qualify as a skilled service, the service must be ordered by a physician, require the skills of professional or technical personnel, and be furnished directly by or under the supervision of such personnel [42 C.F.R. 409.31-35 (1993).] The need for skilled services must be clearly documented in the client's record.

Intermediate Services (IS)

IS 1. Daily monitoring of a significant medical condition requiring overall care planning in order to maintain optimum health status. The individual should manifest a documented need, which warrants such monitoring.
IS 2. Supervision of moderate/severe memory, either long or short term, manifested by disorientation, bewilderment, and forgetfulness which requires significant intervention in overall care planning.
IS 3. Supervision of moderately impaired cognitive skills manifested by decisions which may reasonably be expected to affect an individual's own safety.
IS 4. Supervision of moderate problem behavior manifested by verbal abusiveness, physical abusiveness, or socially inappropriate/disruptive behavior.

Functional Deficits (F)

F1 Requires extensive assistance (hands-on) with dressing and toileting and eating and physical help in bathing. **(All four must be present and, together, they constitute one deficit.)**
F2. Requires extensive assistance (hands-on) with locomotion.
F3. Requires extensive assistance (hands-on) to transfer.
F4. Requires frequent (hands on) with bladder or bowel incontinent care; or with daily catheter or ostomy care.

A person can meet the intermediate level of care criteria in either of two ways: 1. by requiring at least one of the four numbered intermediate services **AND** having one of the numbered functional deficits; **OR**
2. by having at least two of the numbered functional deficits

TC = Total Care see SKS #12 above
MI = Medically Ineligible
AR = HIV/AIDS At Risk for Hospitalization