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08.10 INTRODUCTION

Individuals who will enter or remain in a nursing home and have applied for Medicaid sponsorship must meet level of care criteria through pre-admission review completed by a **CLTC Nurse Consultant** in order to be determined medically eligible. Medicaid vendor payment is authorized by the issuance of the Level of Care Certification Letter, DHHS Form 185, which certifies medical necessity. (See Chapter 9 for other necessary actions relative to PASARR.) This policy applies to all ages.

08.20 NURSING HOME POLICIES AND PROCEDURES

08.21 Choice of Locus of Care

A written locus of care must be secured from the applicant to ensure that the applicant is involved in planning his/her long term care. This locus will remain in effect until such time as the applicant changes his/her locus choice or the case is terminated. An available primary contact may sign the Participant Service Choice, DHHS Form 164, if the applicant requests or lacks the physical or mental ability required to make a written choice regarding his/her care. In these cases, if a primary contact is not physically present, efforts should be made to make a phone contact with the primary contact to discuss locus and document the discussion in the Comment Section of the form. The absence of a signature from the applicant and/or primary contact must be documented in the Comment Section of the Participant Service Choice, DHHS Form 164. However, certification should not be denied if a written choice cannot be obtained.

If a **Nurse Consultant** is asked to do a nursing home certification and the applicant refuses to sign a locus choice indicating nursing home, the **Nurse Consultant** should counsel with the applicant and family or interested agency and try to negotiate the disputed locus of care. When a capable applicant is presented with realistic options and ultimately chooses community placement, the **Nurse Consultant** should support that decision. However, when the applicant's choice is unrealistic and the choice puts the applicant in an unsafe situation, the **Nurse Consultant** should inform the applicant that the choice is not in keeping with his/her service needs. All efforts made in this area should be carefully documented. The **Nurse Consultant** should also consider making a referral to DSS Adult Protective Services for further intervention. Once this is done, the locus choice is still the applicant's decision. Even though a CLTC Certification may be issued, this does not constitute disregard for the applicant's choice nor should it be considered assistance with nursing home placement.

08.22 Nursing Home Certification

CLTC has been designated to perform pre-admission review of all applicants for Medicaid-sponsored nursing home care. This function must occur prior to admission to a long term care facility and before the date for which Medicaid vendor payment can begin. This certification includes the designation of an appropriate level of care. Level of care certification is necessary only when an applicant is determined to be at a skilled or intermediate level of care and will enter or remain in a nursing home with Medicaid as the primary payment source. Level of care certification is accomplished by completing a Certification Letter, DHHS Form 185, at the time of nursing home admission.

When an applicant at home is seeking nursing home admission and is not

participating in a waiver program, the applicant may be certified and closed upon level of care determination.

For those applicants in a nursing home at the time of referral, a certification may be completed upon the level of care determination.

Careful attention must be given to the effective date of the certification requested by the nursing facility. There are different policies for the effective date of certification. (See Sections 08.24 and 08.25.)

Prior to nursing home admission, applicants who appear potentially eligible for extended care benefits through Medicare should be identified and the provider should be instructed to pursue Medicare reimbursement. A level of care is not completed and a Certification Letter is not issued for these cases. If an applicant is eligible for Medicare and Medicaid and under Medicare sponsorship in a nursing facility, a certification letter is not required for a hospital bed hold period. When Medicare benefits are terminated, the applicant may be referred to CLTC for evaluation of Medicaid sponsorship.

Note: If a nursing facility is under denial of payment sanctions, CLTC will be notified. New admissions on or after the effective date of the denial cannot be certified. However, applicants who entered that facility prior to the denial of payment date can be certified for the purpose of converting to Medicaid sponsorship.

- If an applicant admitted prior to the denial of payment date, is admitted to the hospital and over stays the ten (10) day bed hold, notify Central Office for consideration.

- If an applicant is both Medicare and Medicaid eligible, with Medicare as vendor payment for nursing facility, a certification letter is not required for bed hold. Nursing facilities should contact SCDHHS Division of Community and Facilities Services.

- CLTC may continue to certify and close persons in the community. If the applicant chooses the nursing facility that is under denial of payment, advise the applicant to speak with the nursing facility.

08.22.10 When CLTC Certification is Necessary

Any application for Medicaid-sponsored nursing home care requires two eligibility determinations: financial and medical. Financial eligibility is determined by Medicaid Eligibility. The authorization of medical necessity, or pre-admission review, is a function of CLTC.

CLTC certification is required in the following situations:

1. Prior to any Medicaid-sponsored admission to a long term care facility from any location;

   Note: The only exception to this is if the admission is a transfer of a current Medicaid recipient from another long term care facility at the same level of care.

2. Prior to re-admission to a long term care facility from any location once Medicaid vendor payment has been terminated;
   a. Re-admission from the hospital if the stay has exceeded a Medicaid 10-day bed hold period. A patient may be in the hospital 10 full days, returning on the 11th day.

   b. Re-admission to a nursing facility when a patient exceeds nine (9) days of the yearly allowable eighteen (18) days of therapeutic leave or de-institutionalization leave of absence; the day the applicant leaves is counted as Day 1 and the day of return does not count; if the applicant returns after the 10th day, a new certification is needed; and,

   c. Re-admission to a nursing facility when a patient exceeds the approved thirty (30) consecutive days for the purpose of participation in an approved rehabilitation program.

      Note: If a long term care facility formally discharges a patient, the bed hold policy does not apply. In such cases, an assessment must be completed and a CLTC Certification obtained prior to re-admission to a long term care facility.

3. Prior to the date Medicaid vendor payment may begin, when a patient's care in a long term care facility is being paid for privately or by Medicare or any other source, and Medicaid sponsorship is being requested;

4. If a time-limited certification has expired and Medicaid vendor payment is to continue;

5. Prior to the admission of a patient from a facility administered by the Department of Mental Health (DMH) to a non-DMH administered long term care facility; and

6. Prior to the admission of an Intermediate Care Facility patient from a facility administered by the Department of Disabilities and Special Needs (DDSN) to a non-DDSN long term care facility.

7. As requested by Eligibility for income trust and transfer penalty case.

08.22.11 Out-of-State Referrals for S.C. Medicaid Nursing Home Placement

The receiving CLTC office must arrange for one of the following options to evaluate the applicant who is residing outside of South Carolina but is seeking S.C. Medicaid sponsored nursing home placement.

Note: The applicant and/or primary contact must be informed to make financial application at the County Medicaid Eligibility.

Applicant Residing in Out-of-State Nursing Home or Hospital

In response to contact from out of state nursing home or hospital, the **Nurse Consultant** sends Assessment and Consent Form, DHHS Form 121 to the facility to complete and return to the Area Office.

The Assessment must be completed by a professional staff member in the out-of-state facility and sent to CLTC with the completed Consent Form, DHHS Form 121, for review. The **Nurse Consultant** must contact the out-of-state facility by telephone **upon receipt of the Assessment** to validate the information for the tentative level of care after team conference per policy. The applicant and/or primary contact, out-of-state facility, and the admitting facility must be informed of the tentative level of care on the CLTC Notification, using the comment section. **Note: Do not include the Appeals Rights because this is a tentative LOC.** The case must be reviewed **in sixty (60) days** to determine case resolution. If the applicant does not plan to enter a nursing facility in the immediate future, the case may be terminated as Did Not Relocate to South Carolina. If the case is closed at this time, a CLTC Notification is sent.

The final level of care must be determined through a visit to the S. C. nursing home **within ten (10) business days** of the applicant's admission to the facility. If the applicant meets level of care, the case will be closed as "entered Nursing Home". If the applicant does not meet level of care, the application/case will be closed in Phoenix as "medically ineligible".

PASARR Policy and Procedure in Chapter 9 must be followed for out-of-state applicants.

Applicant Residing in Out-of-State Residence

The Consent Form, DHHS Form 121, is sent by the **Nurse Consultant** and must be signed by the applicant and/or primary contact and returned to CLTC. The **Nurse Consultant** will complete the Assessment by a telephone call to the applicant and/or primary contact to obtain accurate information. The CLTC Notification, using the comment section, must be sent to the applicant and/or primary contact and the admitting facility to notify the involved parties of the tentative level of care after team conference per policy.
Note: Do not include the Appeals Rights with this notification because this is a tentative LOC.

The case must be reviewed **in sixty (60) days** to determine case resolution. If the applicant does not plan to enter a nursing facility in the immediate future, the case may be terminated as "Did Not Relocate to South Carolina" and the CLTC Notification is sent.

The final level of care must be determined through a visit to the S.C. nursing home **within ten (10) business days** of the applicant's admission to the facility. If the applicant meets level of care, the case will be closed as "entered Nursing Home". If the applicant does not meet level of care, the case will be closed as "medically ineligible" and policy and procedure for termination will be followed. (Refer to Section 03.22.)

PASARR Policy and Procedure in Chapter 9 must be followed for out-of-state applicant.

Out-of-State Applicant Who Does Not Appear To Meet Level of Care

Upon receiving the completed Assessment from the Out-of-State facility or residence, if the applicant does not appear to meet criteria for level of care, the applicant and/or primary contact must be contacted by phone to discuss the level of care. The N**urse Consultant** contacts the physician or physician's office staff to discuss the medical information. The CLTC Notification must be sent to the applicant and/or primary contact, facility, and others, as appropriate, to indicate that, based on the information obtained, the applicant does not appear to meet the level of care for S.C. Medicaid nursing home placement.

Note: Do not include the Appeals Rights because this is a tentative LOC.

The application/case must be closed as "medically ineligible".

08.22.12 Medicaid Managed Care Organization Enrollee

For a Medicaid MCO enrollee, the Medicaid requirements of participation for nursing facilities apply, including level of care certification, preadmission screening and resident review (PASARR), resident assessment, patient's rights, etc. The MCO must obtain a level of care certification from CLTC for a Medicaid MCO program member prior to admission to the facility. The Certification Letter will have an effective period of **45 calendar days**.

The **Nurse Consultant**, in addition to the above, must complete the following tasks:

- Reviews completed assessment and follow policy for assessment.
- Follows policy in Chapter 3 for level of care determination.
- If referral for Medicare for skilled applicant is appropriate, completes CLTC Notification and instructs **Support Staff** to send to applicant and agency, if appropriate. Terminates as "Referred to Medicare" in Phoenix.
- Follows Policy 08.24 for retroactive certification, if appropriate.
- Follows Policy 08.25 for time-limited certification, if appropriate.
- Follow Policy 08.22 for completing Level of Care Certification Letter, DHHS Form 185, and instructs **Support Staff** to mail copies to agencies and person designated on form. A copy must be sent to the applicant's MCO and a copy faxed to 803-255-8232, attention

SCDHHS Managed Care Enrollment.

- Follows Policy 08.22 Note for nursing facility under denial of payment sanctions.
- Completes Nursing Home Certification in Phoenix.
- Terminates application/case in Status Change section of Phoenix as "entered nursing home".

The correspondence file is routed to the **designated Support Staff** who makes copies of correspondence and mails as indicated, then files correspondence file.

08.23 Conversion from Private Pay, Medicare, Other Payment Sources to Medicaid

When a resident exhausts Medicare, private pay or other resources, he/she may be eligible for Medicaid sponsorship.

Medicare remains the primary payment source until one of the following situations occurs:

1. Medicare benefits are exhausted; or

2. An applicant is no longer receiving Medicare reimbursed skilled service(s).

The resident and/or family must make an application for financial eligibility determination at the Medicaid Eligibility office. The Medicaid Eligibility office will, at the time of this application, send a Request for Assessment, DHHS Form 1231, to the long term care facility in which the applicant resides. Staff of the long term care facility is responsible for completing an Assessment form and forwarding it to the CLTC Area Office.

The Assessment should be completed and sent by the facility, whenever possible, **prior to, or on the date of application** for Medicaid financial eligibility. Nursing homes have been advised that at the very latest, the assessment form must be received in the local CLTC Area Office **within 10 calendar days** of the conversion date. Sometimes a nursing home may anticipate the need for conversion from Medicare or another payment source to Medicaid and request a future date of certification. If this is the case, CLTC staff should not issue a Level of Care Certification Letter, DHHS Form 185, on information that is submitted **more than two weeks prior** to the requested date. The **Nurse Consultant** should be aware of any changes which occur in the applicant's condition before certifying.

Prior to determining a level of care, an assessment by the CLTC **Nurse Consultant** is required. After making a level of care determination, CLTC will send a Level of Care Certification Letter, DHHS Form 185, to applicant/primary

contact and copies to the Medicaid Eligibility office, and the nursing home. The effective date on the Certification Letter should correspond to the date requested by the nursing facility or the Medicaid Eligibility office. (See Section 08.24-Retroactive Certification). If no date is requested, certification is issued based on the date level of care is determined.

08.23.10 Re-Certification of Nursing Home Cases Pending Medicaid Approval

This section pertains to the applicant that is certified and then is determined not to meet financial eligibility. The applicant then applies for conversion to Medicaid **within 180 calendar days** when he/she becomes financially eligible.

An applicant can be re-certified **within a 180-day** period from the original date of certification if the applicant continues to await Medicaid financial eligibility. The Consent Form, DHHS Form 121, and the Client Service Choice Form, DHHS Form 164, remain valid for **the 180-day period**. A referral must be processed via Centralized Intake in the Phoenix Application section following all intake policy for documentation and application/case processing. The **Nurse Consultant** completes a new Assessment in Phoenix through a visit or telephone contact with the nursing facility staff, or others as appropriate, and follows policy and procedure for completing a level of care.

If the applicant continues to await Medicaid-sponsored nursing facility placement **past the 180-day period**, all policies and procedures must be followed regarding Intake, Assessment, and Level of Care. (Including obtaining a new Consent Form, DHHS Form 121 and Client Service Choice, DHHS Form 164).

If the applicant appears to be medically ineligible or if there are any questions concerning the information obtained, a visit must be made to the applicant before the level of care is determined.

The **Nurse Consultant**, in addition to the above policy, completes the following:

- Annotates the narrative and completes the corresponding nurse consultant checklist.

- Terminates application/case in the Status Changes section of Phoenix as “entered nursing home” and completes the Nursing Home Certification in Phoenix.

- Completes Level of Care Certification Letter, DHHS Form

185 and instructs **designated Support Staff** to mail copies to agencies and persons designated on the form.

08.24 Retroactive Certifications

The nursing facility, Medicaid Eligibility, and the CLTC **Nurse Consultant** should coordinate carefully to assure certifications are issued as close as possible to the date of financial eligibility. Retroactive level of care certification will not be routinely authorized by the **Nurse Consultant** for more than 10 days prior to the date of receipt of the referral at Central Intake. Requests for retroactive certification for **more than 30 days** must be referred to the **Area Administrator** or designee in the **Area Administrator's** absence. This must be done prior to saving and completion of the assessment in Phoenix. Review of the case will be completed by the **Area Administrator** with contact from the **Central Office**, as needed. **The Area Administrator must confer with the Central Office prior to denying a retroactive certification.**

In cases where an applicant is dually eligible for Medicare and Medicaid, and Medicare denies benefits, the CLTC office may complete a certification retroactive to the applicant's date of admission or the date Medicare benefits terminate provided the applicant is medically and financially eligible. The nursing facility should submit an Assessment, reflecting the applicant's condition at the time requested. The effective date of certification should be requested on the Assessment. Supportive documentation such as copies of the applicant's nursing facility record or any correspondence from Medicare may be requested from the facility.

The **Nurse Consultant** must visit the applicant at the nursing facility, assess the applicant's current status, and review the applicant's record for the time period requested.

The **Nurse Consultant**, in addition to the above, must complete the following:

- Follow policy for intake, assessment and level of care determination.
- Complete, if skilled or intermediate, Level of Care Certification Letter, DHHS Form 185, with effective date as indicated by the facility, unless retroactive certification or certification for future date is being requested.
- If retroactive certification, determine circumstances of request and obtains documentation to support level of care. Advises facility to make an internal level of care change if has changed from retroactive date to current date.
- Annotate in the narrative and corresponding nurse consultant checklist.

- Terminate application/case in Phoenix completing the Nursing Home Certification.

- Route correspondence file to **Support Staff**.

The **Support Staff** verifies case closure in Phoenix, mails copies of correspondence, and files the correspondence file.

08.25 Time-Limited Certifications

An applicant's medical condition, or other functional factors, may sometimes warrant certification and nursing facility admission for a specific period of time. In these situations, CLTC has determined that the patient can benefit from temporary placement in a long term care facility. Such placement will have specified time frames and goals in the care plan developed by the nursing facility staff. **The Nurse Consultant** should notify the nursing facility, in writing, of the applicant's disability (ies) and short-term needs. This information will be valuable to the facility in the development of the care plan to meet the applicant's short-term needs.

At the end of a certification period the nursing facility should submit an Assessment to CLTC for level of care evaluation if there is a need for continued nursing facility placement. If possible, the **Nurse Consultant**, who completed the original assessment, should contact the nursing facility **ten (10) calendar days** prior to the expiration date to determine if an additional assessment needs to be completed for level of care. The assessment must be submitted **at least seven (7) calendar days** before the expiration due date, by the nursing facility. If the CLTC **Nurse Consultant** determines that an applicant meets the skilled or intermediate level of care, a Certification Letter, DHHS Form 185, will be issued, with no time limit.

When certifying an applicant who will not immediately enter a nursing facility but will receive a time-limited certification, the normal 30-day expiration date on the Level of Care Certification Letter, DHHS Form 185, should be indicated and marked along with the time-limited certification block. At the time of admission to the nursing facility, a new Certification Letter, DHHS Form 185, should be issued indicating the time period covered by the time-limited certification.

If there is a need for a change in level of care during a time-limited certification period, the nursing facility should forward an Assessment Form 1718 and a signed CLTC Consent Form 171 to the CLTC Area Office.

In addition to the above, the **Nurse Consultant** completes the following:

- Consults with team member to determine level of care.
- Completes Level of Care Certification Letter, DHHS Form 185, indicating it is time limited.
- Completes the CLTC Notification of applicant's short-term disability/needs and expiration date of time-limited certification.
- Terminates in Phoenix as "entered nursing home". Completes the Nursing Home Certification.
- Routes the record to **designated Support Staff**, who verifies the case is closed in PHOENIX, assures copies are sent to designated persons, and files the record.

08.26 Certification Validity

Certification for a person awaiting nursing facility placement is valid for 30 calendar days. Thirty days begin with the effective date on the Certification Letter, DHHS Form 185, and end with the expiration date.

Note: A Certification Letter for a Medicaid HMO enrollee has an effective period of 45 days.

The expiration date is a valid date of certification for the applicant to enter the nursing facility. If the applicant has not entered the nursing facility by the expiration date on the Certification Letter, the applicant's condition must be re-evaluated. (Refer to Section 08.28-Re-Certification Policy.) Upon admission to a long term care facility, certification is valid indefinitely unless:

1. Medicaid benefits are terminated for any reason;
   Exception: A Medicaid recipient's benefits are terminated for **31 days or less** for financial eligibility reasons (e.g., excess resources).
2. CLTC has specified that the certification is time-limited (See Section 08.25);
3. Medicaid certification is automatically canceled when an applicant enters a facility with a payment source other than Medicaid; the applicant must again be certified before a Medicaid conversion will be allowed; and,
4. The applicant's condition or location from where s/he was initially certified changes (e.g., home to hospital or long term care facility to home); the only exception to this rule would be the nursing home's option

to hold a bed for up to 10 days for an applicant who has been transferred to a hospital; if the applicant **returns to the nursing home on the 11th day or before**, certification by CLTC is not necessary.

A Level of Care Certification Letter, DHHS Form 185, must not be altered by anyone. In cases where an error has been made, the Certification Letter must be destroyed and a new one completed. Any Certification Letter which has been altered is invalid. If an error is noted or change is requested after the certification is sent, a new corrected certification needs to be completed and sent with a notification in red ink: "Corrected Copy".

08.27 Assessment Reviews for Applicant Awaiting Placement

If a waiver participant changes the locus choice to nursing home, the **Case Manager** should complete a referral to Centralized Intake electronically for Pre-admission Screening application. The waiver application and services should continue. The **Case Manager** should re-verify locus choice, and document in the narrative when notified a nursing home bed has been located for the participant.

When an applicant, with a nursing home locus, has been assessed at a skilled or intermediate level of care by a **Nurse Consultant** and a nursing home bed is unavailable, this applicant is categorized as "awaiting placement". If the awaiting placement applicant changes his/her location of care (e.g., discharged home, enters hospital) prior to admission to a nursing home, the **Nurse Consultant** should complete an update or a new assessment. An update can be completed if there are no significant changes in the applicant's ADL/medical status. However, if there are significant changes, a new assessment must be completed. This review (re-evaluation or update) by the **Nurse Consultant** can be completed through a visit to the applicant or telephone contact with the applicant and/or primary contact, or hospital staff as needed to obtain accurate case information.

CLTC is responsible for reviewing the assessment information as needed to expedite certification for the following awaiting placement cases:

08.27.10 Waiver Participant Awaiting Placement

When the nursing home placement **is imminent**, the review must be completed by the **Nurse Consultant**. If there are significant changes in the participant's ADL/medical status, a new Assessment must be completed in Phoenix. A re-evaluation must always be accompanied by a re-determination of the participant's level of care. This level of care determination must be completed by two **Nurse Consultants**. If there have been no significant changes in the participant's status, an update can be completed and the

participant's status documented in the Narrative.

This information can be obtained through a visit with the participant or telephone contact with the participant's, primary contact and/or other permitted caregiver supports, as appropriate (e.g., home health, medical record, physician's office, service provider). A participant's choice for nursing home placement must again be verified at the time of certification.

A Level of Care Certification Letter, DHHS Form 185, is issued by the **Nurse Consultant.** When the participant enters the nursing home, the **Case Manager** closes the waiver application in the Status Changes section of Phoenix as "Enters Nursing Home". The **Nurse Consultant** completes the Nursing Home application and terminates the nursing home placement application in the Status Changes section of Phoenix and sends appropriate forms. (Refer to Chapter 10-Termination.) The correspondence file is then routed to the designated **Support Staff** to file.

08.27.11 Non-Waiver Hospital Based Awaiting Placement Applicant

When nursing home placement is imminent, the **Nurse Consultant** must review the case by completing a new assessment or an update in the narrative. The applicant service choice is verified and documented in the narrative. A tentative level of care is determined after the initial visit to the applicant. The **Nurse Consultant** follows policy for determining level of care in Chapter 03.21. The review (update or re-evaluation) can be accomplished by a visit or by telephone contact with the hospital staff. If the applicant appears to be medically ineligible, a visit must be made prior to the final level of care determination. (Refer to Section 03.24) The **Nurse Consultant** completes Level of Care Certification Letter, DHHS Form 185, and then instructs the **designated Support Staff** to mail copies to agencies and persons designated on the form. Terminates application/case in Status Changes section of Phoenix as "Enters Nursing Home" and completes Nursing Home Certification.

08.27.12 Non-Waiver Community-Based Awaiting Placement Applicant

A Level of Care Certification Letter, DHHS Form 185, is issued after the initial evaluation and the application/case is terminated as "certified and closed" in Phoenix, if no bed is available. If a bed is available, then terminates as "Entered Nursing Home". The **Nurse**

Consultant should inform the applicant and/or primary contact to notify CLTC if the certification has expired and nursing home placement is imminent. If the applicant enters a nursing home **within a 180-day period** from the original date of certification, re-certification can be completed. (See Section 08.28)

The Awaiting Placement Report below is completed once a month by the **Lead Team Nurse Consultant**:

- Towards the end of each month, Central Office will provide the Area Office with a report of applicants who are awaiting placement.
- Each applicant on the list will be contacted to verify that he/she is still seeking nursing home placement after the narrative is reviewed for current information. All contacts and information should be documented in the Narrative.
- If closing or updating the application, go to Application, then Status Change. Change Application Status. For closure, if the applicant has entered the nursing home, choose AWP-Review-In NH. Enter the effective date which is the date the application is closed.
- Any person on the list no longer seeking nursing home placement should be updated in Phoenix **by close of business the last working day of the month.**
- For applicants still seeking nursing home placement, one of the reasons shown below should be noted on the CLTC Area Office report.
- The **Area Administrator** will review this report **monthly** to ensure accuracy.

	Still Awaiting Placement
	Died
	Moved out of state
	Not Awaiting Placement
	Nursing Home
	Unable to locate (Could not contact applicant, PC, referral source, etc.)
	No contact (Attempted contact, message left)
	Terminated (2nd month contact could not be made with anyone. Terminate in Phoenix)
Indicate date called, if narrative updated and if Phoenix updated.	

08.28 Re-Certification of Non-Waiver Applicant

The applicant who has been certified and closed can be re-certified **within a 180-day** period, from the original date of certification. The Consent Form, DHHS Form 121, and the Service Choice Form, DHHS Form 164, remain valid for the 180-day period. The locus choice must be verified again and documented in the narrative. A referral for the Re-Certification must be completed. The **Centralized Intake Team** will release the application to the Area Office. The designated **Support Staff** assigns the application to the Nurse Consultant. The **Nurse Consultant** completes the assessment through a visit or telephone contact with the applicant and/or primary contact and/or other permitted caregiver supports as appropriate, and follows policy and procedure for intake and level of care determination. If the applicant appears to be medically ineligible, a visit must be made prior to the final level of care determination. The **Nurse Consultant** terminates the case in the Status Changes section of Phoenix as "entered nursing home" if placement is imminent or "certified and closed" if continues to await nursing home placement. The Level of Care Certification Letter, DHHS Form 185 is completed by the **Nurse Consultant**. The **designated Support Staff** mails copies to agencies and persons designated on the form.

If the applicant continues to await placement **beyond this 180-day time period**, the **Nurse Consultant** must visit the applicant, and follow policies and procedure for intake, assessment and level of care (including obtaining a Consent Form, DHHS Form 121, and Service Choice, DHHS Form 164.)

08.29 Other Institutional Nursing Care Programs

08.29.10 Administrative Days

A Medicaid applicant (regardless of age) who is presently residing in an acute care hospital, has received acute care services, and no longer requires acute care may be eligible for Administrative Days. Other payment sources must be exhausted to be eligible for the Administrative Days Program. The applicant must meet the South Carolina Level of Care Criteria and have a nursing home locus. CLTC will determine a level of care or a tentative level of care.

The tentative level of care can be relayed to the hospital with the CLTC Notification by the **Nurse Consultant**. The hospital may use this for billing purposes for Administrative Days. The use of the tentative level of care is reserved for those applicants that are expected to be admitted to a nursing facility **within 14 calendar days**. The application/case remains open and pending hospital discharge.

If the stay exceeds **14 calendar days**, the final level of care should

be determined, by the **Nurse Consultant** and a Certification Letter, DHHS Form 185, should be completed. The effective date and expiration date on the Certification Letter should not be completed for Administrative Days certification. Once a Certification Letter is issued, the application/case is terminated as "entered Administrative Days." If the applicant is determined to be medically ineligible, the **Nurse Consultant** closes the case as "medically ineligible," and completes the Level of Care Certification Letter, DHHS Form 185.

This certification or CLTC Notification is valid indefinitely unless CLTC is notified by the hospital that the applicant is to be admitted into a nursing facility. Re-certification for nursing home admission policy can be followed if the applicant enters a nursing facility. **Designated Support Staff** mails copies to agencies and persons, as appropriate.

Waiver Participant Entering Administrative Days

If a waiver participant chooses to enter Administrative Days, the assigned **Case Manager** should refer the case to Centralized Intake for an application for nursing home placement and PASARR as appropriate. The **assigned Nurse Consultant** completes the required activities as above.

The effective date and expiration date should not be completed for Administrative Day certification. **The waiver participant must be terminated from the CLTC program when entering Administrative Days**. The **Case Manager** terminates the waiver application in Phoenix as "entered Administrative Days" if meets level of care criteria. If medically ineligible, the case must be closed as "medically ineligible" and the CLTC Notification must be issued. The **Case Manager** is responsible for completing the appropriate forms to terminate waiver application and services. The **designated Support Staff** is instructed to mail copies to agencies and persons, as appropriate. Re-certification for nursing home admission policy can be followed if the applicant enters a nursing facility.

Re-Certification For Nursing Home Admission

An individual in the Administrative Days program can be re-certified **within a 180-day period** from the original date of certification if the individual enters a nursing home from the Administrative Days Program. The case will be processed through

intake in Phoenix. The Consent Form, DHHS Form 121, and the Service Choice Form, DHHS Form 164, remain valid **for the 180-day period**. The locus choice must be verified again and documented in the Narrative. The **Nurse Consultant** completes the assessment through a visit or telephone contact with the discharge planner, social worker or others, as appropriate, and follows policy and procedures for completing the level of care determination. If the individual appears to be medically ineligible, a visit must be made prior to the final level of care determination. If a request for certification is received **after the 180-day period**, the case must be processed following policy and procedures for intake, assessment, and level of care. The **Nurse Consultant** must visit the individual, complete a Consent Form, DHHS Form 121, and a Service Choice Form, DHHS Form 164.

The Certification Letter is issued and the application/case is terminated as "entered the nursing home".

Exception: If an individual is entering the nursing facility as Medicare skilled, the Certification Letter, DHHS 185, will not be issued.

Special Situations in Dealing With Administrative Days

- If an applicant has been discharged from a hospital and was never seen by CLTC, hospital should contact the Department of Health and Human Services' Division of Hospitals regarding Administrative Days. The hospital will be asked to forward physician's progress notes for review.

- If the individual has been discharged from the hospital and was seen by CLTC while in the hospital, the CLTC Notification issued with the tentative level of care can be used by the hospital or a Certification Letter, DHHS Form 185, may be issued based on the status of the individual when seen by CLTC.

- If the individual is currently in the hospital and the hospital requests retroactive Administrative Days, the Certification Letter, DHHS Form 185, should be issued based on current conditions.

  Note: If the individual appears medically ineligible at present but appeared to meet level of care for the date of request based on medical records, put a corresponding end

date on the Certification Letter, DHHS Form 185.

- If the hospital requests Administrative Days and the individual is not currently eligible for Medicaid, CLTC determines the level of care as usual. CLTC is only verifying level of care by issuing the Certification Letter, DHHS Form 185.

- If the individual goes from Administrative Days to acute care back to Administrative Days within the same hospital stay, a new Certification Letter, DHHS Form 185, or CLTC Notification, DHHS Form 171, does not have to be completed each time.

08.29.11 Subacute Care

The Subacute Care Program is a program for ventilator dependent patients. Prior hospitalization is not required. The applicant may be admitted from a community setting. All applicable PASARR regulations apply and all applicable policy and procedure for nursing home placement apply and must be followed by the **Nurse Consultant**. However, a nursing home locus is not required. A Certification Letter, DHHS Form 185, will be issued and the case will be terminated as "entered nursing home". The Certification Letter must have the Subacute Care block checked if the applicant is ventilator dependent and the level of care must be skilled. The **designated support staff** sends appropriate correspondence then files record if not instructed to re-route to **Nurse Consultant**.

08.29.12 Swing Bed

A swing bed is a nursing home bed which is located in a hospital with a swing bed contract with the Department of Health and Human Services. Prior to admission under Medicaid, the applicant must meet the South Carolina Level of Care Criteria (skilled or intermediate) and have a nursing home locus. Also, Medicare swing bed should be explored as an option first. Prior or recent hospitalization is not required. Applicants may be admitted to swing beds from community settings. Once the applicant is determined eligible (level of care) the **Nurse Consultant** will issue a Certification Letter, DHHS Form 185, and the case will be terminated as "entered the nursing home." (For PASARR regulations, see Chapter 9.)

08.29.13 Hospice Enrolled Applicants Seeking Nursing Home Certification

Applicants who are enrolled in the hospice benefit must meet the same requirements for re-certification as other applicants. (See Section 8.22)

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.

08.29.14 Nursing Home Transition Service

Participants who are transitioning from the nursing home or who have been discharged home from the nursing home within the last 10 days may be eligible for the Nursing Home Transition service. Refer to Chapter 7 Nursing Home Transition service addendum.