Health, Department of

Medicaid

Chapter 22: Evaluation of Medical Necessity for Medicaid Long Term Care Programs

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CHAPTER 22

Rules and Regulations for Medicaid

Evaluation of Medical Necessity for Medicaid Long Term Care Programs

Section 1. Authority.

This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. § 42-4-104 and the Wyoming Administrative Procedure Act at W.S. § 16-3-102.

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to establish methods and standards for evaluations of medical necessity for applicants and clients seeking nursing facility services, swing bed services, Long Term Care Home and Community Based Waiver services (LTC HCBS), Assisted Living Facility Home and Community Based Waiver services (ALF HCBS), or the Program of All-Inclusive Care for the Elderly (PACE).

Section 3. Definitions. Except as otherwise specified in Chapter 1 or as defined herein, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, Medicaid, and Medicare.

(a) "Evaluation of Medical Necessity." A review by a medical necessity evaluator of an applicant's/client's mental and physical condition, to assess the individual's functional ability, for the purpose of determining whether or not the individual requires nursing facility level of care to be reimbursed by Medicaid.

(b) "Medical necessity evaluator." A registered nurse who is under contract with the Department to function as a medical necessity evaluator. In situations where no contract exists, designated staff of the Department shall perform the evaluation with input and advice from the local medical professionals.

Section 4. Evaluations of Medical Necessity.

(a) Purpose. To determine whether an applicant or client requires nursing facility services, swing bed services, LTC HCBS or ALF HCBS Waiver services, or PACE services equivalent to a nursing facility level of care.

(b) Applicability.

(i) All nursing facility, swing bed, LTC HCBS or ALF HCBS Waiver, and PACE applicants or clients shall undergo an evaluation of medical necessity which

determines that nursing facility level of services are medically necessary before a provider may receive Medicaid reimbursement for services provided to that individual.

(ii) Regardless of payment source, any nursing facility or swing bed client who is referred for a PASRR Level II evaluation shall undergo an evaluation of medical necessity as part of the determination of appropriateness of nursing facility placement, if the client does not have a valid evaluation of medical necessity as specified in this section.

(c) Criteria. The medical necessity evaluator shall determine whether nursing facility, swing bed, LTC HCBS or ALF HCBS Waiver, or PACE services are necessary by evaluating individuals according to criteria specified by the Department.

(d) Transfers.

(i) The facility to which a client requests to transfer shall not receive Medicaid reimbursement for services provided to the client unless the requirements of Section 4, Evaluations of Medical Necessity, are met.

(ii) Any client requesting a transfer between the LTC HCBS Waiver Program, ALF HCBS Waiver Program, or PACE Program shall be evaluated if the client does not have a valid evaluation of medical necessity, as specified in this section, prior to the transfer request.

(iii) Any client requesting a transfer to or from a nursing facility and the LTC HCBS Waiver Program, ALF HCBS Waiver Program, or PACE Program shall be evaluated if the client does not have a valid evaluation of medical necessity, as specified in this section, prior to the transfer request.

(e) Readmissions. A client who is discharged and subsequently requests readmission to a facility shall be evaluated pursuant to this section, and the facility shall not receive Medicaid payment for services provided to the client if the client does not require a nursing facility level of care.

(i) A client who is discharged from a facility and requests readmission to the facility shall be evaluated if the client does not have a valid evaluation of medical necessity as specified in this section.

(f) Redetermination of Medicaid eligibility. A client who loses Medicaid eligibility and subsequently requests a redetermination of Medicaid eligibility shall be evaluated pursuant to this Section, even if the individual has not been discharged from a program or facility. The facility in which the individual resides or into which admission is sought shall not receive Medicaid payment for services provided to the client if the level of care provided by that facility is not medically necessary.

(g) Procedure.

(i) A referral for nursing facility placement may be made by the nursing facility, hospital, Medicaid Long Term Care Eligibility Unit staff, or any representative of the individual to be evaluated.

(A) The referral shall be communicated to the Department by the requesting person or entity indicating that an individual is requesting admission to or on the premises of a nursing facility and needs an evaluation of medical necessity.

(B) A referral for a medical necessity evaluation for the LTC HCBS or ALF HCBS Waivers or PACE Program may be made only by the Department when the client applies for the specific program.

(ii) Evaluations of medical necessity shall be performed by the medical necessity evaluator under guidelines outlined in the contract between the Department and the evaluating agency.

(iii) If the evaluation determines that the level of care offered by the facility or program is not medically necessary, the medical necessity evaluator shall deliver a written denial letter to the applicant or client within three (3) working days, by hand-delivery, first class mail, or certified mail. If mailed, the date of receipt shall be deemed to be three (3) days after the date of the denial letter if sent by first class mail, or the date signed for if sent by certified mail.

(iv) The effective date of the evaluation of medical necessity shall be the date the evaluation is performed.

(h) Validity of evaluation of medical necessity.

(i) An evaluation confirming medical necessity pursuant to this section is valid for ninety (90) days from the date of the evaluation.

(ii) When a client applies for Medicaid while residing in a nursing facility, a new evaluation shall be performed if one has not been completed in the previous ninety (90) days.

(iii) If the evaluation of medical necessity is less than ninety (90) days old at the time of application for Medicaid eligibility, it will be considered valid for eligibility determination purposes, regardless of the length of time the eligibility determination process takes.

(i) Re-evaluations.

(i) Nursing facility residents shall receive continued stay reviews as

follows:

(A) When a nursing facility identifies that a client's functional ability has improved, indicating the client may no longer need nursing home level of care required for Medicaid eligibility, the facility shall request a new evaluation of medical necessity in writing to the Department, regardless of the length of the client's stay in that facility.

(B) Continued stay reviews shall be performed six (6) months from the date of the medical necessity evaluation that determines Medicaid eligibility.

(C) Continued stay reviews shall be completed when a resident's condition has changed substantially in accordance with Chapter 19.

(ii) Clients of LTC HCBS and ALF HCBS Waiver services or PACE services shall receive re-evaluations of medical necessity per the guidelines set forth in the applicable waiver agreements and state plan amendments.

(iii) If more than one (1) evaluation is performed, for any reason, the results of the most recent evaluation will determine medical necessity.

(j) Not a guarantee of eligibility. An evaluation of medical necessity that determines that nursing facility, swing bed, LTC HCBS, ALF HCBS Waiver, or PACE services are medically necessary shall not be a guarantee of the individual's eligibility for Medicaid or of Medicaid reimbursement for services provided to the individual.

Section 5. Medicaid Reimbursement.

(a) Completion of an evaluation of medical necessity. No facility shall receive Medicaid reimbursement for nursing facility services provided to a client until:

(i) The medical necessity evaluator has completed an evaluation of medical necessity which indicates that nursing facility services are medically necessary; and

(ii) The nursing facility has complied with Chapter 19.

(b) Continued stay reviews for residents of nursing facilities.

(i) When a continued stay review indicates that nursing facility services are no longer medically necessary, the provider shall complete a discharge notice and deliver the notice to the resident or the resident's representative within five (5) working days from the date of the evaluation. A copy of the discharge notice shall be sent to the appropriate Medicaid Long Term Care Eligibility Unit staff on the same day it is given to the resident or the resident's representative.

(ii) Medicaid reimbursement shall continue for services provided to the resident for up to thirty (30) days after the date of the delivery of the discharge notice.

(c) Re-evaluations of medical necessity for clients of LTC HCBS or ALF HCBS Waiver services or PACE services.

(i) When a re-evaluation of medical necessity indicates that LTC HCBS or ALF HCBS Waiver or PACE services are no longer medically necessary:

(A) A notice of denial of service letter shall be given to the client by the medical necessity evaluator.

(B) Upon notification of the adverse decision of the evaluation of medical necessity, the case manager shall complete a discharge notice (HCBS10) and deliver it to the client.

(ii) Medicaid reimbursement shall continue for services provided to the client until the last day of the approved plan of care.

(d) Retroactive payments. Retroactive payments may be available pursuant to Chapter 19.

Section 6. Recovery of Overpayments. The Department shall recover overpayments pursuant to Chapter 16.

Section 7. Reconsideration.

(a) Request for reconsideration.

(i) A provider shall not request that the Department reconsider a determination of medical necessity made pursuant to this Chapter.

(ii) An applicant, client, or their representative may request that the Department reconsider an adverse determination of medical necessity made pursuant to this Chapter. Such requests shall be submitted to the Department in writing within ten (10) days of the date the client or applicant receives the denial letter from the medical necessity evaluator.

(b) Reconsideration. The Department shall review the request and order that a second evaluation of medical necessity be performed by a different evaluator. Clients currently receiving Medicaid services shall continue to receive those services during reconsideration.

(c) Request for additional information. The Department may request additional

information from the applicant or client as part of the reconsideration process. The requested information shall be provided within thirty (30) days after the date of the request. Failure to provide the requested information shall result in the dismissal of the reconsideration. Information may be obtained from the medical necessity evaluator as part of the reconsideration process.

Section 8. Administrative Hearing.

(a) An applicant, client, or their representative may request an administrative hearing regarding the determination that nursing facility, swing bed, LTC HCBS or ALF HCBS Waiver, or PACE services are not appropriate or medically necessary. The request for an administrative hearing shall be made pursuant to Chapter 4.

(b) Scheduled medical necessity evaluations may be deferred during the hearing process.

(c) Clients receiving Medicaid services shall continue to receive those services during the hearing process.

Section 9. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

Section 10. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals and/or bulletins, which are inconsistent with this Chapter.

Section 11. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.