Senate Committee on Health and Human Services
Charge 4 – Medical Necessity Review

Department of Aging and Disability Services

Commissioner Chris Traylor

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Long-term Services and Supports

- The Texas Department of Aging and Disability Services (DADS) provides long-term services and supports to a wide range of individuals. Long-term services and supports are services to meet an individual's health or personal care needs over an extended period of time and may include:
  - Assistance with bathing, toileting, dressing, eating
  - Meal preparation
  - Relief for caregivers
  - Home modifications and repairs
  - Transportation
  - Adaptive aids
  - Services at licensed facilities
  - Nutrition services such as home-delivered meals or meals at senior centers

- These populations include:
  - Individuals with physical disabilities
  - Individuals with intellectual and developmental disabilities
  - Individuals age 60 and older, their family members and other caregivers, who are eligible for services under the Older Americans Act

- DADS also regulates providers of long-term services and supports.

Medicaid Programs

- Medical Necessity – Physician certification of need for daily or regular skilled nursing:
  - Nursing Facility
  - Community Based Alternatives (CBA)
  - Medically Dependent Children Program (MDCP)
- Diagnosis of Intellectual or developmental disability or related condition :
  - Home and Community-based Services (HCS)
  - Community Living Assistance and Support Services (CLASS)
  - Texas Home Living (TxHmL)
  - Deaf Blind with Multiple Disabilities (DBMD)
- Physician statement certifying need for assistance with activities of daily living (bathing, feeding, toileting):
  - Primary Home Care (PHC)
  - Community Attendant Services (CAS)
  - Day Activity and Health Services (DAHS) – Adult Day Care

Medical Necessity – Nursing Facility

- To verify that medical necessity exists, an individual must meet the conditions described in 40 Texas Administrative Code (TAC) §19.2401:
  - The individual must demonstrate a medical condition that:
    - is of sufficient seriousness that the individual's needs exceed the routine care, which may be given by an untrained person; and
    - requires licensed nurses' supervision, assessment, planning, and intervention that are available only in an institution.
  - The individual must require medical and nursing services that:
    - are ordered by a physician;
    - are dependent upon the individual's documented medical conditions;
    - require the skills of a registered nurse or licensed vocation nurse;
    - are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and
    - are required on a regular basis.

Medical Necessity Determination Process

- The nursing facility completes the Minimum Data Set (MDS) assessment which begins the process for determining medical necessity.

- Automated medical necessity determination - the MDS assessment is reviewed to determine if the assessment includes any conditions for which the automated system could determine medical necessity (e.g., ventilator or feeding tube).

Medical Necessity Determination Process

- Manual medical necessity determination - if an MDS assessment does not have sufficient information to meet the automated medical necessity criteria, the assessment is reviewed manually by a registered nurse by the State's Medicaid contractor.
  - If the MDS assessment has sufficient information to meet the medical necessity criteria in 40 TAC §19.2401, medical necessity is approved.
  - If a MDS assessment does not have sufficient information to meet the medical necessity criteria in 40 TAC §19.2401, the MDS assessment is retained for twenty-one days to:
    - Allow the nursing facility to provide sufficient additional information.
    - The MDS assessment and any additional information submitted are reviewed by a nurse and are either:
      - Approved by a registered nurse, or
      - Sent to a physician for a medical necessity determination.
    - If medical necessity is denied, the applicant or recipient is notified by letter and provided a right to a fair hearing to appeal the denial of medical necessity.

Minimum Data Set (MDS) Assessments

- An MDS assessment identifies each resident's functional capabilities and health problems to assist in providing appropriate care.
- The MDS assessment includes information about the individual's hearing, speech, and vision; mental status; mood; behavior; functional status; bladder and bowel continence; active diagnosis; health conditions; swallowing/nutritional status; skin conditions; medications; and special treatments, procedures and programs.
- An MDS assessment must be completed:
  - Initially at admission to the nursing facility
  - Every 92 days thereafter; and
  - Upon significant change in condition
- The MDS assessment must be completed by a registered nurse at the nursing facility.

Resource Utilization Group (RUG)

- When the MDS assessment is submitted by the nursing facility, a resource utilization group (RUG) is determined based on the types and amount of care indicated in the assessment.

- The RUG determines the daily reimbursement rate paid to a nursing facility for each day at a Medicaid nursing facility.

- The RUG only determines the daily reimbursement rate the nursing facility will be paid for providing services to the individual. An individual must have a determination of medical necessity for nursing facility care before the nursing facility can be paid for services.

Permanent Medical Necessity

- Permanent medical necessity is established in accordance with DADS rule at 40 TAC §19.2403(e)(1) which states:
  - A recipient's permanent medical necessity status is established on the completion date of any MDS assessment approved for medical necessity no less than 184 calendar days after the recipient's admission to the Texas Medicaid Nursing Facility Program.

- Permanent medical necessity was established to prevent individual's from being discharged from a nursing facility when the individual had no home to return to.

Oversight of Medical Necessity Determination Process

- The State's Medicaid contractor makes medical necessity determinations as part of the Medicaid claims administrator contract between HHSC and Affiliated Computer Services (ACS).

- DADS monitors the contractor's performance in regard to medical necessity determinations.
  - Performance of medical necessity determinations is monitored through self-reported data produced by the contractor.
  - The reports demonstrate the number of denials and approvals of medical necessity each month for the nursing facility program as well as any identified problems with medical necessity determinations.

Office of Inspector General Utilization Review

- Consists of approximately 76 nurse and administrative staff responsible for performing reviews.
- Reviews conducted of nursing facility RUG classification reviews and hospital fee-for-service paid claims.
- Approximately 400 nursing facility reviews conducted per year.
- TAC requires one nursing facility review every 15 months.
- RUG reviews consist of assessing the accuracy of items coded for reimbursement.

Office of Inspector General Utilization Review

- Implemented medical necessity reviews as of February 13, 2012.
  - Statistical sample of PA1 and PA2 population:
    - PA1 and PA2 are RUGs for lowest level of care required
    - Sample sizes range from 100% review to a minimum of 34 forms representing a statistically valid random sample
    - Plan to extrapolate the results
    - Review period 1-2 years (2008-2010)

- Future reviews: expand medical necessity reviews to codes beyond PA1 and PA2.

Process Improvements

- DADS is developing a process whereby DADS staff would perform retrospective reviews of manual medical necessity determinations approved by contractor nurses.

- These retrospective reviews would include a review of all information used by the contractor nurse to make the medical necessity determination, including the MDS assessment and all information the contractor nurse received from the nursing facility.

Medicaid Waiver Programs

Nursing Facility Waiver Programs

- Community Based Alternatives (CBA)
- Medically Dependent Children Program (MDCP)

Intermediate Care Facilities for Persons with Intellectual Disabilities Waiver Programs

- Home and Community-based Services (HCS)
- Community Living Assistance and Support Services (CLASS)
- Texas Home Living (TxHmL)
- Deaf Blind with Multiple Disabilities (DBMD)

Eligibility and Enrollment Process
Community Based Alternatives (CBA)

- Individuals age 21 years and older.
- DADS case managers conduct face-to-face, in home, assessments to determine need for program services.
- The home health agency conducts a medical necessity and level of care (MN/LOC) assessment (MDS based).
- The State's Medicaid contractor determines the medical necessity and the level of care based on the RUG.
- DADS case managers finalize the individual service plan and authorize the services.
- Services can be received in home, assisted living or adult foster care settings.

Eligibility and Enrollment Process
Medically Dependent Children Program (MDCP)

- Individuals age 20 years and younger.
- DADS case managers conduct face-to-face, in home, assessments to determine need for program services.
- DADS registered nurses conduct a medical necessity and level of care (MN/LOC) assessment (MDS based).
- The State's Medicaid contractor determines the medical necessity and level of care based on the RUG.
- DADS case managers finalize the individual service plan and authorize the services.
- The individual must live with a family member or with a foster family (no more than four children are unrelated).

Eligibility and Enrollment Process
Home and Community-based Services (HCS) & Texas Home Living (TxHmL)

- No age limit.
- Local Authority assesses and documents programmatic eligibility to ensure individual:
  - Has a primary diagnosis of intellectual disability, or related condition (e.g., autism, cerebral palsy, spina bifida, down syndrome) with coexisting cognitive deficit (I.Q. of 75 or less).
  - Has significant impairment in adaptive functioning (e.g., requires ongoing assistance with activities of daily living, behavior intervention).
- Service planning team develops individual plan of care in accordance with the individual's person directed plan.
- DADS staff reviews the proposed plan and authorizes the enrollment.

Eligibility and Enrollment Process
Community Living Assistance and Support Services (CLASS)

- No age limit.
- Direct Service Agency assesses and documents programmatic eligibility to ensure individual:
  - Has a primary diagnosis of related condition (e.g., autism, cerebral palsy, spina bifida, down syndrome).
  - Has significant impairment in adaptive functioning (e.g., requires ongoing assistance with activities of daily living, behavior intervention).
  - Has an ongoing need for habilitation services that support an individual to reside in a community setting. Services may include training an individual to acquire, retain, and improve self-help, socialization, and daily living skills or assisting the individual with Activities of Daily Living.
- Direct services agency registered nurses conduct face-to-face assessments to determine if required criteria are met.
- Service planning team develops individual plan of care.
- DADS staff reviews the individual plan of care and if appropriate authorizes funding for services.

Eligibility and Enrollment Process
Deaf Blind with Multiple Disabilities (DBMD)

- No age limit.
- Provider agency assesses and documents programmatic eligibility to ensure individual:
  - Has a primary diagnosis of deaf blindness or a condition that leads to deaf blindness (may have a diagnosis of rubella or Charge syndrome) and have a coexisting disability (e.g., intellectual disability, related condition).
  - Has significant impairment in adaptive functioning (e.g., requires ongoing assistance with activities of daily living, behavior intervention.
- Provider agency staff conduct face-to-face assessments to determine if required criteria are met.
- Service planning team develops individual plan of care.
- DADS staff reviews the individual plan of care and if appropriate authorizes funding for services.

Utilization Management and Review

- Conducted across all entitlement and waiver programs to ensure individuals receive the services and supports they need – no more and no less.
- Types of reviews include:
  - concurrent (randomly sampled individuals currently enrolled in the program)
  - prospective (pre-authorization reviews based on specific program criteria or thresholds)
  - Medical Necessity/Level of Need reviews
  - retrospective reviews (hospice only)
- Methods include:
  - face-to-face visits with individuals receiving services
  - desk reviews of service justification documentation
  - combinations of face-to-face and desk review
- Utilization review conducted by DADS registered nurses and Qualified Intellectual Disability Professionals.