DPHHS Senior and Long Term Care Division (SLTCD)

Medicaid Nursing Facility Add-On Application

Pursuant to Administrative Rules of Montana (ARM) 37.40.330(2), Medicaid nursing facilities are eligible for an enhanced rate payment to assist with safe, effective, and appropriate service delivery to at-risk populations residing in long-term care facilities. The Senior and Long Term Care Division requires a prior authorization review to occur prior to the Department's authorization of eligible add-on funding for complex care. Mountain Pacific Quality Health (MPQH) program staff will evaluate the applications based on documentation from the requesting provider to determine that:

- The request is for extreme cases according to the complex care levels that are medically necessary and relates specifically to the resident's diagnosis and documented plan of care.
- The request will coincide with one of the complex care levels and provide a direct medical or remedial benefit to the resident adhering to health and safety standards and clinical best-practices.
- The request is for residents who need care that is "above and beyond" the normal standard of nursing facility care that are noted in the complex care levels below.
- Individuals with tracheotomy or ventilator care will continue to be evaluated for prior authorization per ARM 37.40.330 and are not covered in the structure below.
- Residents must be Medicaid eligible to be able to participate.

Submission Process

Please submit Medicaid Add-On Applications online to MPQH on the MPQH website.

For questions or instructions on how to submit the form, choose the **Education and Training button** on the MPQH website and follow the guidance for the process. For additional information or technical assistance, use the Contact Us button on the MPQH webpage.

Important: Descriptions provided are for introductory and/or evaluation purposes only; therefore, exceptions will be evaluated in collaboration with the requestor and applied on a case-by-case basis and/or in the event of emergency situations. All cases will be reviewed and must have all necessary documentation to be considered.

Medicaid Nursing Facility Add-On Complex Care Levels

Complex Care Level	Description	Rate
Level I Minimal Assist-Infrequent Intervention	**Behavioral**: Low level of care and need for occasional assistance and support in one or more ADLs with conditions that require limited additional assistance. Have a diagnosed health disorder with history of demonstrated disruptive behaviors that occur on an infrequent basis of 1-4 times per week and require staff intervention.	$75.00
Level II Stand-By Assist-Moderate Intervention or Assistance Care	**Behavioral**: Moderate level of care with need for more assistance with ADLs compared to Level I. Level of assistance varies depending on resident needs. Have a diagnosed health disorder with history of demonstrated disruptive behaviors that occur on a regular basis of more than 4 times a week. Greater assistance is required to redirect and assure safety of the resident. **Bariatric**: Residents **over 350 pounds** but under 650 pounds who require ADL assistance from more than one staff member. May include wound care associated with skin breakdown due to weight. **Wound Care**: Interventions for residents with a stage 3 wound. Full thickness tissue loss. Subcutaneous fat may be visible, but bones, and tendons are not exposed. May include some undermining or tunneling. Dressing changes up to 2 times a day, pain management, pressure reductions and increased infection control.	$150.00
Level III Total Assist-Direct Intervention and Assistance Care	**Behavioral**: High level of care and extensive and frequent assistance. Residents with diagnosed severe mental or physical ailments that impact their ability to live independently. May need around-the-clock assistance from multiple caregivers to support them. Assistance needed with administering medications, performing medical treatments, help with all ADLs, and management of daily difficult behavior changes. Intense assistance is required to redirect and assure safety of the resident. **Bariatric**: Residents who are **over 650 pounds**. Require major assistance with ADLs and repositioning that require more than one staff member. May include some wound care associated with skin breakdown due to weight. **Wound Care**: Interventions for residents with stage 4 wound. Full thickness tissue loss. Subcutaneous fat, bones, tendons, and muscle are exposed. Eschar and slough are present. Greater than 2 dressing changes or use of wound VAC, frequent monitoring and pain management, pressure reduction and increased infection control.	$225.00

The following situations are not eligible for assignment to Levels II and III:

- Individuals at risk of elopement without aggressive or assaultive behaviors
- Individuals enrolled in Hospice care.

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

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Complex Care Levels Request Form

Applicant and Facility Information

Applicant Name _____ Medicaid ID _____

Facility Name _____ Provider ID _____

Type of Request

☐ New Request

☐ Continued Request – Provide Current Documentation from the last 90 days.

Level Requested

☐ Level I ☐ Level II ☐ Level III

Diagnoses

30 Day Summary of Clients Needs/Condition and Behaviors (include resident goals relating to the request)

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Required Documentation

☐ Complex Care Levels Request Form

☐ Face/demographic sheet

☐ History and physical (most recent)

☐ Care plan

☐ Applicable progress/chart notes

☐ Current medication and treatment orders

☐ Behavior chart log (behavior only)

☐ Behavioral plan (behavior only)

☐ Nutritionist order with current documented weight (bariatric only)

☐ Wound care team notes (wound care only)

Documentation should include information from the last 1-3 months. Documentation submitted must reflect frequency and severity of the behaviors and each behavior must be documented separately. Facilities must demonstrate that the resident has a history of persistent disruptive behavior that is not easily altered and requires an increase in resources from nursing facility staff. Additional documentation may be requested as necessary and failure to submit the required documentation could result in denial. For HIPAA compliance, it is not advisable that providers submit more medical records than requested.

When multiple conditions exist, the level will be authorized based on the highest conditions. For continuation of any services, updated records and care plans must be submitted and reviewed by MPQH. Authorizations related to wound care will be authorized for 90 days and all other services for 180 days.

Per ARM 37.40.330 (2), denials, or approvals at a lower level than requested will be explained in the acceptance/denial letter.