

TennCare Long Term Services and Supports: A Guide for Pre Admission Evaluation Applications



A guide for all certified assessors of persons in a nursing facility or in the community who are applying for TennCare reimbursed long-term services and supports provided through TennCare CHOICES, PACE and IFC-IDD



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1.0 INTRODUCTION

TennCare is committed to meeting the needs of Tennessee residents. We offer a broad array of long-term care services designed to help meet the needs of the elderly, chronically ill, physically disabled and/or intellectually disabled. Long-Term Services & Supports (LTSS) CHOICES is a variety of services which help meet both the medical and non-medical needs of people with a chronic illness, physical disability and/or intellectual disability who cannot care for themselves for long periods of time. It is common for long term care to provide custodial and non-skilled care, such as assisting with normal daily tasks like eating and using the bathroom. Increasingly, long term care involves providing a level of medical care that requires the expertise of skilled practitioners to address the often multiple chronic conditions associated with older populations. Long-term care can be provided at home, in the community, in assisted living (or other community based residential alternative) or in a nursing home. Long-term services or supports may be needed by people of any age, even though it is a common need for senior citizens. TennCare uses medical information provided on the Pre Admission Evaluation (PAE) application to determine medical eligibility (level of care) for long term care programs. This manual outlines the actions necessary to complete and submit PAEs for three programs offered by TennCare to provide LTSS CHOICES, Program of All-Inclusive Care for the Elderly (PACE), and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)—serve the elderly, physically disabled, and intellectually disabled populations. These populations and the services offered are specifically defined in this TennCare LTSS PAE Manual.

There are three groups in CHOICES. Participation in CHOICES Group 1 is limited to TennCare members who qualify for and are receiving TennCare-reimbursed Nursing Facility (NF) services. Participation in CHOICES Groups 2 and 3 is limited to TennCare members who qualify for and are receiving TennCare-reimbursed HCBS (Home Care Based Services). Group 3 is limited to individuals who are SSI (Supplemental Security Income from the Social Security Administration) recipients.

The **Program of All-inclusive Care for the Elderly (PACE)**, is a managed care program providing frail, elderly (age 55 and older) Medicare and Medicaid members with comprehensive medical and social services at an adult day health center, at home, and/or inpatient facilities, using an interdisciplinary team and integrated care planning approach. For most participants, the comprehensive service package permits them to continue living at home rather than in an institution while receiving services. PACE is currently available in Tennessee only in Hamilton County. Services are offered through the PACE Organization under contract with TennCare.

The Intermediate Care Facilities for Individuals with Intellectual Disabilities and Intellectual

Disability Waiver Programs were established for individuals with a diagnosis of intellectual disability (ID) prior to the age 18. These individuals must qualify financially for Medicaid services as determined by TennCare member services. And, to receive TennCare reimbursed long term services and supports (LTSS) an individual must meet medical eligibility criteria for the applicant type of institutional care as determined by TennCare. Medical eligibility, or level of care (LOC) is largely based on functional deficits in a person's ability to perform Activities of Daily Living.

For CHOICES, PACE, and IFC-IID, **Level of Care (LOC)** is the medical eligibility component; Financial eligibility is the financial portion) for Medicaid reimbursement of long term services and supports. Both components are necessary to qualify for LTSS through TennCare. TennCare has many partners who conduct assessments and submit PAEs which are used to determine an individual's appropriate level of care need. These include MCOs, **Area Agencies on Aging and Disability (AAAD)**, nursing homes, hospitals and the PACE organization and ICF/IID facilities. PAE applications are submitted to TennCare using a web based software application known as The PAE Tracking System. PAE applications are reviewed and adjudicated by registered nurses with TennCare's Division of Long Term Services and Supports. The assessments completed and submitted as part of the PAE application enables TennCare to meet its fiscal and clinical responsibilities of ensuring that persons are matched to the most appropriate and least resource intensive and restrictive level of care to meet their needs.

1.1 PURPOSE AND SCOPE

The purpose of this guide is to provide instruction and guidance regarding the PAE application process. It is critical that qualified persons complete the PAE in its entirety, being careful to accurately assess each functional area and to submit sufficient medical evidence to support the assessed level of function. Assessors must also be thorough in their review of the assessment outcomes and supporting documentation prior to certifying a PAE's accuracy.

This guide is to be used in conjunction with PAE Application which includes these sections:

- Identifying Information for the Applicant
- Pre-Admission Screen and Resident Review PASRR Functional Assessment
- Skilled Nursing and/or Rehabilitative Services
- Enhanced Respiratory Care
- Requesting a Safety Determination
- Certification of Assessment
- Diagnosis
- Required Attachments
- PAE Effective Request Date
- Certification of Level of Care by MD, DO, PA, NP or APN Certification
- Update (or Recertification)(NF only)

This manual is also to be used in conjunction with LTSS Operational Protocols, memos, monthly newsletters, PAE Tracking System training curriculums and informational updates. These can be found on the LTSS page of the TennCare website. The Ascend website is an additional resource that is readily available PASRR/LOC

This manual provides general instructions regarding the completion and submission of the CHOICES, PACE, and IFC-IID PAE Application including specific instructions pertaining to each section. Assessors should become familiar with this manual and use it as a reference document.

1.2 AUTHORITY

This document draws from a combination of federal and state laws which specify the standards and procedures that must be followed in determining medical eligibility for NF services, IFC-IID, and HCBS.

The primary authority and basis for the protocols and directives outlined in this guide are from TennCare Rule 1200-13-01.

The Bureau of TennCare's Division of Long Term Services and Supports administers and oversees operation of CHOICES and PACE in partnership with contracted Managed Care Organizations and sponsoring PACE organization.

1.3 CONFIDENTIALITY

TennCare uses a series of policies, forms and agreements to ensure Health Insurance Portability and Accountability Act (HIPAA) compliant use and disclosure of Protected Health Information (PHI). This information can be reviewed online on the TennCare website. TennCare encourages

all partners and providers to always be mindful of HIPAA requirements when completing actions described in this manual.

1.4 ATTACHMENTS

There is a series of attachments included with this manual. These attachments are updated by TennCare on both a regular basis and as changes occur. Each attachment included is also available on the TennCare website, and in many cases on the PAE Tracking System and ASCEND homepage. When using any of the attachments as part of your daily processes, we recommend that you go to the TennCare or ASCEND website and print the most recent version of the document.

2.0 MEDICAL ELIGIBILITY ENROLLMENT DECISIONS

The purpose of the PAE is to submit to TennCare an application for Medicaid reimbursement of long term services and supports. Level of Care (LOC) is also known as medical eligibility for LTSS. For both CHOICES and PACE there are two components of LOC eligibility:

- Medical necessity of care; and
- Need for inpatient care, or
- Need for home care based services

2.1 MEDICAL NECESSITY OF CARE

Medical necessity of care, need for inpatient care, and need for home care based services is addressed in detail by program in the manual sections titled “NF LOC CHOICES-- Group 1”, “HCBS CHOICES Group 2”, “HCBS--CHOICES Group 3”, “PACE”. And “IFC-IID”.

2.2 LEVEL OF CARE ACUITY SCALE

The total acuity score is calculated using the assessment of certain functional and clinical needs. The clinical needs as captured on the PAE are skilled and/or rehabilitative services (e.g., tube feeding, wound care, occupational therapy, physical therapy, non-chronic ventilator care) and Enhanced Respiratory Care (ERC). The functional needs as captured on the PAE include the applicant’s need for assistance with the following Activities of Daily Living (ADLs):

- Transfer;
- Mobility;
- Eating; and
- Toileting;

And deficits in the following ADL-related functions:

- Communication (expressive and receptive);

- Orientation (to person, place, or event/situation);
- Behaviors; and
- Self-administration of medications

The TennCare NF LOC Acuity Scale is included with attachments. (Attachment A)

3.0 FINANCIAL ELIGIBILITY

To qualify financially for Medicaid long-term care, an applicant's income can't exceed 300% of the **Federal Benefit Rate (FBR)**. If it is, a Qualifying Income Trust may be set up. AND, the total value of things owned can't be more than \$2,000. A person's home where he/she lives doesn't count. Also not counted is a person's vehicle (more than one vehicle may count as an asset). And, a person can't have given away or sold anything for less than what it's worth in the last five (5) years.

4.0 LONG TERM SUPPORT SERVICES ENROLLMENT

A person must be enrolled in a TennCare long-term care program in order to receive TennCare reimbursed LTSS. For purposes of this manual, this means that a person must be enrolled in CHOICES or PACE before TennCare will pay for nursing facility services or HCBS. There are distinct requirements for enrollment into each CHOICES group and PACE as specified in TennCare Rule. These requirements are detailed throughout the chapters for Group 1, Group 2, Group 3, PACE, and IFC—IID. It is important for PAE submitters to also review enrollment decisions as indicated in TPAES.

4.1 INITIATION OF LTSS ENROLLMENT

How a person initiates the enrollment process into CHOICES depends primarily on whether the person is already enrolled in TennCare or is applying for Medicaid at the same time as CHOICES. This may also be impacted by whether the person is receiving services in a Nursing Facility at the time of application.

1. For persons who are not Medicaid eligible at the time of application for

CHOICES and are seeking HCBS, AAADs are designated as the Single Point of Entry (SPOE) into the CHOICES program. AAADs may also assist persons seeking NF services; however, individuals seeking Medicaid reimbursement of NF services are not required to go through the SPOE to enroll in CHOICES Group 1. AAADs are permitted by TennCare

Member Services to facilitate the Medicaid application process (i.e., complete the application and gather all documentation required to make a Medicaid financial eligibility determination) and are contracted by TennCare to complete and submit to TennCare the PAE application.

2. For HCBS applicants who are already Medicaid eligible at the time of CHOICES referral, MCOs perform intake functions, including completion and submission of the PAE to TennCare. MCOs may also assist NF applicants who are already enrolled in Medicaid.
3. For persons applying for services in a Nursing Facility (including applicants already receiving NF services at the time of application e.g. private pay residents spending down their personal resources or dual eligible individuals who are exhausting their Medicare SNF benefit), NFs frequently complete and submit the PAE to TennCare and may also assist the person in filing a Medicaid application.
4. For persons applying for services through PACE, a referral should be made to the PACE Organization. PACE staff will complete a comprehensive assessment and submit the PAE to TennCare. PACE staff may also assist the person in filing their Medicaid application.

4.2 PROGRAM SPECIFIC ENROLLMENT CRITERIA

Specific enrollment criteria for CHOICES Groups 1,2, 3, PACE, and IFC-MR is discussed in detail located in Chapters 5, 6, 7, 8, and 9, respectively.

4.3 ADDITIONAL ENROLLMENT INDICATORS

CHOICES and PACE “carry over” group (“Grandfathered”):

For applicants who qualified for and were enrolled in CHOICES or PACE prior to July 1, 2012, only care|| provision of NF LOC eligibility. These individuals are in the “carry over” group and have an enrollment status that is referred to as “grandfathered.”|| Documentation regarding these individuals is found in the TennCare Medicaid Management Information System (MMIS—also called Interchange). TennCare eligibility and enrollment information is sent to Managed Care Organizations from the MMIS and provided to PACE staff and service providers via TN Anytime.

TennCare relies on the MMIS and other safeguards to ensure that the correct standards are applied when determining level of care. CHOICES and PACE enrollees who are in the carry over group as “grandfathered” will continue to be required to meet the standards in place prior to July 1, 2012 for the duration of their time in the program. TennCare’s federal partners at the Centers for Medicare and Medicaid Services (CMS) approved allowing TennCare to “grandfather” existing NF residents and those already receiving home-based care so long as they continue to meet the LOC criteria in place at the time of enrollment and remain continuously eligible and enrolled in the CHOICES Group or PACE, as applicable.

4.4 ENROLLMENT DECISIONS

Once the PAE has been adjudicated by a TennCare RN, enrollment decisions may be reviewed in the PAE Tracking System.

5.0 NURSING FACILITY LEVEL OF CARE “CHOICES GROUP 1”

This chapter provides information and guidance to facilitate the assessment or data collection, decision making, and PAE submission necessary for individuals applying for CHOICES Group 1 or Nursing Facility Level of Care.

5.1 MEDICAL NECESSITY OF CARE

Care in a nursing facility must be expected to improve or ameliorate the individual’s physical or mental condition, to prevent deterioration in health status, or to delay progression of a disease or disability, **and** such care must be ordered and supervised by a physician on an ongoing basis. For individuals applying for nursing home care, the medical necessity of care criteria is satisfied through Physician, MD, DO, PA, NP or APN as applicable signature and printed name on the PAE Certification Form (attachment B) and in The PAE Tracking System on the Certification Tab. The PAE Certification Form requires an original certifier signature and National Provider Identifier (NPI) number. PAEs will not be approved or reviewed further unless the form is filled out in its entirety and the certifier has signed the statement on the PAE Certification page certifying that the applicant requires the level of care provided in a Nursing Facility and that NF services are

ordered by the certifier and that the requested long term care services are medically necessary for the applicant. Anytime it appears that a Certification Signature is duplicated or not an original signature, a referral to TennCare's Program Integrity Unit must be made.

5.2 NEED FOR INPATIENT NF CARE

To satisfy the need for inpatient care aspect of LOC, the individual must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The individual must be unable to self-perform needed nursing care and must:

- Have a total acuity score of at least 9 on the TennCare NF LOC Acuity Scale; or
- Meet at risk LOC (described below) on an ongoing basis **and** be determined by TennCare to not qualify for enrollment in CHOICES Group 3 based on a Safety Determination.

5.3 NF LOC ACUITY SCALE

The total acuity score is calculated using the assessment of certain functional and clinical needs. The clinical needs as captured on the PAE are skilled and/or rehabilitative services (e.g., tube feeding, wound care, occupational therapy, physical therapy, ventilator care, enhanced respiratory care (ERC). The functional needs as captured on the PAE include the applicant's need for assistance with the following Activities of Daily Living (ADLs):

- Transfer;
- Mobility;
- Eating; and
- Toileting;

And deficits in the following ADL-related functions:

- Communication (expressive and receptive);
- Orientation (to person, place, or event/situation);
- Behaviors; and
- Self-administration of medications

The TennCare NF LOC Acuity Scale is attached. (Attachment A)

5.4 QUALIFICATIONS FOR ENROLLMENT IN NF LOC GROUP 1

To qualify for NF LOC Group 1 the application must:

1. Have completed the **Pre –Admission Screening and Resident Review (PASRR)** process and be determined appropriate for NF placement
2. Have an approved, unexpired PAE for NF LOC (this will be determined through the PASRR process when the applicant is Medicaid payer or Medicaid pending payer)
3. Be approved financially for TennCare reimbursement of NF services

4. Be admitted to a NF; and
5. Have a Medicaid Only Payer Date, or;
6. Be admitted to the NF in Path Tracker (see PASRR process)

5.5 PRE-ADMISSION SCREENING RESIDE ENROLLMENT DECISIONS INTREVIEW (PASRR) (NF REQUESTS ONLY)

Reminder: The entire PASRR process must be completed before a NF LOC determination can be made for Group 1 requests.

APPROPRIATE PASRR

An appropriate PASRR is one that is:

- negative (without a subsequent determination that PASRR should be positive;
- positive with a determination that NF placement is appropriate (if short term, PAE should be end dated to reflect) OR;
- positive with a determination that a dementia diagnosis overrides an MI or ID diagnosis

A level I PASRR screen must be submitted via the Ascend web based system for all persons being admitted to a Medicaid certified NF regardless of payer source and regardless of disability. If the applicant has a suspected or diagnosed serious mental illness intellectual disability or developmental disability the PASRR level I screen must be submitted into the ASCEND system If referred for a Level II, a LOC screen will be required and may replace the need for a PAE submission via the PAE tracking system.

The PASRR Level I screen is submitted to ASCEND and will be determined to be either negative or positive.

- A negative Level I screen requires no further action.
- A positive Level I screen will indicate either presence or suspicion of SMI (Serious Mental Illness, ID (Intellectual Disability) or DD (Developmental Disability).
 - For a positive Level I screen with SMI, ID, or DD:
 - a categorical determination may be granted or
 - an exemption may be granted or
 - a referral will be made for a comprehensive Level II evaluation

The submitter will be required to submit a Level of care screen and if the individual is determined to have a Level II PASRR condition, LOC will be determined as part of the Level II PASRR determination.

PASRR CATEGORICAL DETERMINATIONS

- Exempted Hospital Discharge (EHD) – a person is currently admitted to the hospital and is going to the NF for treatment of the condition for which he/she received hospital care, and whose physician certifies will likely require 30 days or fewer of NF services.
- Convalescent Care – a person is currently admitted to the hospital and is going to the NF for treatment of the condition for which he/she received hospital care, and whose physician certifies will likely require 60 days or fewer of NF services.
- Terminal Illness – a person has a terminal illness, and whose physician certifies he/she has a life expectancy of 6 months or less. This outcome provides 180 calendar days in the NF.
- Severe Physical Illness – a person who has a coma, ventilator dependence, functioning at brain stem level, or diagnoses, such as, Parkinson’s disease, Huntington’s disease, or ALS, which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services. This is not a time limited stay, although the person’s physician must certify the individual’s condition. A new Level I screen should be submitted should there be any improvement in the person’s physical condition.
- Dementia and ID – a person has an intellectual disability and dementia and whose physician certifies the condition.
- Respite – a person who resides in a community setting and requires a brief NF admission to provide respite to in-home caregivers. Up to 9 days for CHOICES members.

As of December, 1, 2016 for individuals that have a PASRR condition, level of care has been determined by ASCEND as part of the level II PASRR process. The PASRR determination is available in the PAE Tracking System; if further information is required the LTSS nurse reviewer may access the ASCEND website to obtain information. The PAE nurse reviewer will check the PAE Tracking System for PASRR and/or LOC determinations prior to PAE adjudication.

AUTHORITY FOR FINAL PASRR DETERMINATIONS

TennCare is contracted with both the Department of Mental Health (DMH) and the Department of Intellectual and Developmental Disabilities (DIDD) who, per federal regulations, have final authority over PASRR Level II determinations.

PASRR APPEALS

During a PASRR LOC appeal, the appeals team will communicate with ASCEND, DMH and/or DIDD to schedule hearing, make changes to determination and assist with the hearing process.

PASRR CONDITION OR SUSPICION OF PASRR CONDITION

In the event that an applicant develops a PASRR condition or suspicion of a PASRR condition after being admitted to the NF or has a significant change in his/her status which may result in a change in the plan of care or need for specialized services, regardless if they have previously been identified through PASRR, a change of status must be submitted by the NF via the ASCEND web based system. If determined by ASCEND that the applicant either has a PASRR condition i.e. serious mental illness, intellectual disability or developmental disability, or has suspicion of a PASRR condition, ASCEND will refer the positive Level I screen for a comprehensive Level II evaluation which will consist of a LOC evaluation. The admitting NF must ensure they are able to provide all specialized services recommended by PASRR prior to admission. If the LOC is denied through the PASRR process, a new PASRR and LOC may be submitted or the submitter may contact ASCEND and request a reconsideration of the application. If the PASRR is not approved after reconsideration an appeal may be requested.

5.6 MEDICAID ONLY PAYER DATE (MOPD):

TennCare must have received notification from the NF that Medicaid reimbursement is requested for the effective date of CHOICES enrollment (i.e., the individual is no longer privately paying for NF services and Medicare payment of NF services is not available) by entering an MOPD into The PAE Tracking System or the admission date entered into Path Tracker. Enrollment into CHOICES Group 1 (and payment of a capitation payment to an MCO for LTSS) cannot begin before the above is satisfied.

If LOC determination is made through the PASRR process, there will be no MOPD but rather an admit date populated in Path Tracker which will serve as the notification to TennCare for the requested effective date of NF reimbursement. See Chapter 11 for additional information regarding determination of MOPD.

5.7 NURSING FACILITY LEVEL OF CARE TRANSITIONS

Transition from CHOICES Group 1 to Group 2

An MCO may request to transition a member from Group 1 to Group 2 only when the member chooses to transition from the NF to a home and community based setting. Members shall not be required to transition from Group 1 to Group 2. Only an MCO may submit to TennCare a request to transition a CHOICES member from Group 1 to Group 2. A member that has already been discharged from the NF shall not be transitioned to CHOICES Group 2. Once a member has been discharged from the NF, he/she has voluntarily disenrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 2. A new

HCBS PAE shall be required for enrollment into CHOICES Group 2. When members move from Group 1 to Group 2, TennCare Member Services must recalculate the member's Patient Liability.

Transition from CHOICES Group 2 to Group 1:

An MCO may also request to transition a member from Group 2 to Group 1 only if the member meets NF LOC criteria, has completed the PASRR process, has a physician order for NF Care, the member is found to be NF appropriate, and at least one (1) of the following is true:

- (i) The member chooses to transition from HCBS to NF.
 - for example: there is a decline in the member's health or functional status or a change in the Member's natural care giving supports; or
 - The MCO has made a determination that the member's needs can no longer be safely met in the community and at a cost that does not exceed the average cost of NF services for which the member would qualify, and the member chooses to transition to the more appropriate institutional setting in order to safely meet his/her needs.

When members move from Group 2 to Group 1, TennCare Member Services must re-calculate the member's Patient Liability. A new NF PAE is always required if the member is enrolled as a "grandfathered" Group 2 member.

If member is found to have a PASRR condition, a new LOC screen will be required as part of the PASRR level II process. These transitions must be reviewed by a nurse to ensure all criteria are met. An appropriate PASRR and signed certification is required.

Transition from CHOICES Group 1 or Group 2 to Group 3:

TennCare or the MCO shall, subject to eligibility and enrollment criteria, initiate a transition from Group 1 or 2 to Group 3 when a member who was enrolled in CHOICES Group 1 or Group 2 on or after July 1, 2012 no longer meets NF LOC but meets At Risk LOC. A member that has already been discharged from the NF shall not be transitioned from CHOICES Group 1 to CHOICES Group 3. Once a Member has discharged from the NF, he has voluntarily disenrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 3. In these instances, the member must qualify for SSI at the time of transition and a new HCBS PAE shall be required for enrollment into CHOICES Group 3.

Transition from CHOICES Group 3 to Group 1 or Group 2:

TennCare or the MCO shall initiate a transition from Group 3 to Group 1 or Group 2, as appropriate, when the member meets NF LOC and satisfies all requirements for enrollment

into the requested Group. When a member transitions from Group 3 to Group 1, TennCare Member Services must recalculate the member's Patient Liability.

Transition information for NFs:

Nursing Facilities and other providers cannot initiate a CHOICES transition for CHOICES members. When a nursing facility believes that a CHOICES HCBS member requires a transition to receive TennCare reimbursed NF services long term, coordination with the MCO must occur. Similarly, when a CHOICES HCBS member admits to a NF for an MCO approved short term stay; a PAE application is not required. Additionally, any skilled and/or rehabilitative service needed during a short term stay is authorized by the MCO and does not require submission of a PAE application. In these instances, the NF must coordinate with the MCO. Typically, a short term stay can be approved for up to 90 Medicaid reimbursed days. The 90 days does not include days reimbursed by another payer source (including Medicare) and does not include bed hold days. Keep in mind that the 10 day bed hold limit is applied across the short-term and long term NF benefit, (i.e. 10 days per member per year).

5.8 NF PAE ASSESSMENTS

Now that you are familiar with CHOICES and understand eligibility and enrollment criteria, we will introduce the process for completing a PAE application so that TennCare may determine level of care, or medical eligibility, for CHOICES and PACE. Remember, for an applicant to qualify for CHOICES Group 1, 2 or PACE, NF LOC must be approved. To qualify for CHOICES Group 3, "At Risk" LOC must be approved. Also, as Chapter 4 described, there are other enrollment and eligibility requirements that must be satisfied prior to an applicant's enrollment into CHOICES or PACE. This section will walk you through preliminary assessment information necessary to conduct assessments for CHOICES NF LOC and PACE applicants.

WHO CAN COMPLETE A NF PAE ASSESSMENT?

Nursing Facility PAE assessors are clinically trained staff (employed by a hospital, nursing home, MCO or AAAD) who have completed an online TennCare training about LTSS Programs and the PAE application process. The assessor must be a Physician (MD or DO), **Physician Assistant (PA)**, **Nurse Practitioner (NP)**, **Advanced Practice Nurse (APN)**, **Registered Nurse (RN)**, **Licensed Practical Nurse (LPN)** or **Licensed Social Worker (LSW)**. The assessor name must be entered into The PAE Tracking System under the certification tab and be signed by the assessor. Sometimes a physician (MD OR DO), PA, NP, APN, RN, LPN, LSW, or TennCare Qualified Assessor allows a PAE to be completed and submitted in The PAE Tracking System by someone else on his/her behalf. In these cases, the physician, PA, NP, APN, RN, LPN, LSW or TennCare Qualified Assessor continues to assume all responsibility for ensuring that the information as submitted is accurate.

NF PAE CERTIFICATION

For all PAEs, Certification that the level of care information provided on the PAE is accurate. Certifiers must also acknowledge that they understand that the information provided is being used to determine Medicaid eligibility and/or reimbursement for long-term services and supports and that any intentional act to provide false information that would potentially result in a person obtaining benefits or coverage that he or she is not entitled to is considered an act of fraud under the State’s TennCare program and Title XIX of the Social Security Act. This certification is captured in The PAE Tracking System on the Certification Tab. The PAE Certification Form is signed and dated by the LOC certifier and is included with the PAE application as an attachment in The PAE Tracking System.

COMPONENTS OF THE NF PAE ASSESSMENT

Remember, there are two components of level of care (LOC) eligibility:

- Medical necessity of care; and
- Need for inpatient care.

The functional assessment and supporting medical evidence included with the PAE application are used to determine if the Need for Inpatient Care requirement is satisfied when determining LOC. Chapter 15 of this manual provides a detailed explanation of: measuring functional deficits; Activities of Daily Living and Daily Living Related Functions; and Enhanced Respiratory Care as well as guidance for finalizing the functional assessment for all LTSS Programs.

5.9 FUNCTIONAL ASSESSMENT

Measuring Functional Deficits

On the PAE, there are 4 possible responses to each question. *Except* for behavior, “**Always**” means that the applicant is **always independent** with that ADL or related activity. “**Usually**” means that the person is **usually independent** (requiring assistance fewer than 4 days per week). “**Usually not**” means that the applicant is usually not independent (requiring assistance 4 or more days per week). “**Never**” means that the applicant is **never independent** with that ADL or related activity.

With respect to behavior, the responses are reversed. “**Always**” means that the applicant always requires intervention for behaviors. “**Usually**” means that the applicant requires intervention for behaviors 4 or more days per week. “**Usually not**” means that the applicant requires intervention for behaviors, but fewer than 4 days per week. “**Never**” means that the applicant does not have behaviors that require intervention.

TennCare has assigned a weighted value to each of the possible responses to each question on the PAE, based on the amount of assistance that would be required for a person with that type and level of ADL or related deficit. The TennCare NF LOC Acuity Scale (Attachment A) provides the weight given to each functional measure and response. Each response must be supported by the medical evidence submitted with the PAE for the assigned acuity score to be approved by TennCare.

5.10 ADLs and ADL-related functions

When providing responses to each functional measure as indicated on the functional assessment, you should consider the act of physical assistance being "hands on" care. You should also consider a person's functionality in a 24 hour/7 days a week window of need. Some patients may appear, during your presence, to be functioning well in an area that they may not function well at in different times/days. For example, someone may be only incontinent at night, but continent the rest of the day. When these types of situations exist, it is important to clearly explain it on the PAE as a note or comments in The PAE Tracking System.

I. Transfer

DEFINITION: Transfer - The applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis. **QUESTION ON PAE:** Can applicant transfer to and from bed, chair or toilet without physical help from others?

HELPFUL HINT: This is moving the body from one place to another without ambulating (which is covered under the Mobility section). It is important to note the definition applies to bed, chair, or toilet only. An example may be that the applicant needs someone to hold onto him to successfully get up/down from the bed and on/off the toilet.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of transfer to and from bed, chair, or toilet without physical assistance from others.
- Usually: Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of transfer to and from bed, chair, or toilet without physical assistance 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit requires documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of transfer assistance required.

*Recommended documentation to support this functional deficit: medical **H**istory and **P**hysical (**H&P**), ADL flow sheets, PT notes, nurse's notes, section "G" of **Minimum Data Set (MDS)***

II. Mobility

DEFINITION: Mobility - The applicant requires physical assistance from another person for mobility on an ongoing basis. Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair (manual or electric) if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

QUESTION ON PAE: Can applicant walk without physical help from others?

HELPFUL HINT: This is the act of moving from one place to another. In other words, if someone is able to get from one place to another using their manual or power wheelchair, this would be considered "mobile". An example may be that the applicant needs someone to hold on to him when he is ambulating with his cane.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of walking without physical assistance.
- Usually: Applicant is incapable of walking unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable walking unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of walking without physical assistance 7 days per week.

Only when the above question is answered with a **UN** (Usually Not) or **N** (Never), follow to the next question under Mobility:

QUESTION ON PAE: If walking is not feasible (answer to mobility question above is UN or N), is Applicant capable of using a wheelchair, either manual or electric?

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of mobility without physical assistance.
- Usually: Applicant is incapable of wheelchair mobility unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of wheelchair mobility unless physical assistance is provided by others 4-6 days per week.

- Never: Applicant is never capable of wheelchair mobility without physical assistance 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of mobility assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, PT notes, nurse's notes, section "G" of MDS

III. Eating

DEFINITION: Eating - The Applicant requires physical assistance with gastrostomy tube feedings or physical assistance or constant one-on-one observation and verbal assistance (reminding, encouraging to consume prepared food and drink or self-administer tube feedings, as applicable) or must be fed part or all of each meal. Food preparation, tray set-up, assistance in cutting up foods, and general supervision of multiple residents shall not be considered to meet this requirement.

QUESTION ON PAE: Can applicant eat (or physically self-administer tube feeding as applicable) without help from others?

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of eating without help from others.
- Usually: Applicant is incapable of eating without help from others 1-3 days per week.
- Usually Not: Applicant is incapable of eating without help from others 4-6 days per week.
- Never: Applicant is never capable of eating without help from others 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation which supports the need for such intervention, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task. For PAEs submitted by the AAAD (or entity other than an MCO, NF, or PACE Organization), an eating or feeding plan specifying the type, frequency and duration of supports required by the Applicant for feeding, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task shall be required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, OT/ST notes, nurse's notes, swallow study, section "G" of MDS

IV. Toileting

DEFINITION: Toileting - The applicant requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or catheter care on an ongoing basis

QUESTION ON THE PAE: Can applicant toilet without physical assistance from others?

HELPFUL HINT: Includes the act of toileting, adjusting clothing and/or being able to properly clean oneself. This does NOT include the act of getting on/off the toilet as this is accounted for in the Transfer question. Incontinence is scored separately, for example someone may usually be able to toilet but is incontinent and can never clean themselves. Some people can have an indwelling catheter and care for it themselves, do not assume the presence of one means the person is never able to self-care. An example may be the applicant needs someone to clean him/herself and help him/her pull up their pants and buckle their belt after toileting.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of toileting without physical assistance.
- Usually: Applicant is incapable of toileting unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of toileting unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of toileting without physical assistance 7 days per week.

Only when the applicant is incontinent, follow to the next question under Toileting:

QUESTION ON THE PAE: Can applicant perform incontinent care without physical assistance from another person on an ongoing basis?

- Always: Applicant is always capable of performing incontinence care without physical assistance.
- Usually: Applicant is incapable of performing incontinence care and requires physical assistance 1-3 days per week.
- Usually Not: Applicant is incapable of performing incontinence care and requires physical assistance 4-6 days per week.
- Never: Applicant is never capable of performing incontinence care and requires physical assistance 7 days per week.

Mark the type of incontinence, Bowel or Bladder.

Only when the applicant has a catheter or ostomy present, follow to the next question under Toileting:

QUESTION ON THE PAE: Can applicant perform catheter/ ostomy care without physical assistance from another person on an ongoing basis?

- Always: Applicant is always capable of performing catheter/ ostomy care without physical assistance.
- Usually: Applicant is incapable of performing catheter/ ostomy care and requires physical assistance 1-3 days per week.
- Usually Not: Applicant is incapable of performing catheter/ ostomy care and requires physical assistance 4-6 days per week.
- Never: Applicant is never capable of performing catheter/ ostomy care and requires physical assistance 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific type and frequency of toileting assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, nurse's notes, section "G" of MDS

V. Orientation

DEFINITION: Orientation - The applicant is disoriented to person (e.g., fails to remember own name, or recognize immediate family members), place (e.g., does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make good decisions that prevent risk of harm)

QUESTION ON PAE: Is applicant oriented to person (remembers name; recognizes family), place (does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make decisions that prevent risk of harm)?

HELPFUL HINT: Please note the definition for orientation to person, place and/ or event/situation only; this does NOT include such things as time, or people who are not immediate family. An example may be the applicant does not know who he/she is and/or where he/she is.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always oriented to person, place and event/situation.
- Usually: Applicant is disoriented to person or place or event/situation 1-3 days per week.
- Usually Not: Applicant is disoriented to person or place or event/situation 4-6 days per week.
- Never: Applicant is never oriented to person or place or event/ situation 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific orientation deficits(s), including the frequency of occurrence of such deficit(s), and the impact of such deficit(s) on the Applicant.

*Recommended documentation to support this functional deficit: H&P, plan of Care, Nurse's notes, psych notes, **Mini- Mental Status Exam (MMSE)**, **Saint Louis University Mental Status (SLUMS)***

VI. Communication

DEFINITION: Expressive and Receptive Communication - The Applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including through the use of assistive devices; or the Applicant is incapable of understanding and following very simple instructions and commands without continual intervention

HELPFUL HINT: Communication includes basic information; not complex instructions or complex needs/wants. Possibly ask the person to raise their hands over their head. This would not be to assess movement, but to assess if the person can follow simple instruction. An example may be that the applicant needs help to let others know that he/she needs to use the toilet.

QUESTION ON PAE: The applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including with the use of assistive devices.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of reliably communicating basic needs and wants.
- Usually: Applicant is incapable of reliably communicating basic needs and wants and requires continual intervention 1-3 days per week.
- Usually Not: Applicant is incapable of reliably communicating basic needs and wants and requires continual intervention 4-6 days per week.
- Never: Applicant is never capable of reliably communicating basic needs and wants and requires continual intervention 7 days per week.

QUESTION ON PAE: The applicant is incapable of understanding and following very simple instructions and commands without continual intervention.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of understanding and following very simple instructions and commands without continual intervention.
- Usually: Applicant is incapable of understanding and following very simple instructions and commands without continual intervention 1-3 days per week.
- Usually Not: Applicant is incapable of understanding and following very simple instructions and commands without continual intervention 4-6 days per week.
- Never: Applicant is never capable of understanding and following very simple instructions and commands without continual intervention 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of communication assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ST notes, Nurse's notes, psych notes, MMSE, SLUMS

VII. Medications

DEFINITION: Medication Administration - The Applicant is not cognitively or physically capable of self-administering prescribed medications at the prescribed schedule despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to Applicant, reassurance of the correct dose, and the use of assistive devices including a prepared medication box. An occasional lapse in adherence to a medication schedule shall not be sufficient for approval of this deficit; the Applicant must have physical or cognitive impairments which persistently inhibit his or her ability to self-administer medications.

QUESTION ON PAE: Is applicant physically or cognitively able to self-administer medications with limited assistance from others (as described above)?

HELPFUL HINT: This includes physician prescribed PO, IM, RX Otics, Ophthalmics, Topicals, Inhalers, Continuous SQ (subcutaneous) Medications, excluding sliding scale insulin.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of self-administration of prescribed medications.
- Usually: Applicant is incapable of self-administration of prescribed medications without physical intervention 1-3 days per week.
- Usually Not: Applicant is incapable of self-administration of prescribed medications without physical intervention 4-6 days per week.

- Never: Applicant is never capable of self-administration of prescribed medications without physical intervention 7 days per week.

Only when the above question is answered with a **UN** (Usually Not) or **N** (Never), you must list, on the PAE, the medications for which assistance is needed, and provide explanation regarding why applicant is unable to self-administer with limited help from others.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require evidence that such interventions have been tried or would not be successful, and that in the absence of intervention, the Applicant's health would be at serious and imminent risk of harm.

Recommended documentation to support this functional deficit: H&P, Plan of Care, order/prescription for medications listed as unable to self-administer, Medication Administration Record (MAR), Nurse's notes, Speech Therapy (ST) notes

VIII. Behavior

DEFINITION: Behavior - The Applicant requires persistent staff or caregiver intervention and supervision due to an established and persistent pattern of behavioral problems which are not primarily related to a mental health condition (for which mental health treatment would be the most appropriate course of treatment) or a substance abuse disorder (for which substance abuse treatment would be the most appropriate course of treatment), and which, absent such continual intervention and supervision, place the Applicant or others at imminent and serious risk of harm. Such behaviors may include physical aggression (including assaultive or self-injurious behavior, destruction of property, resistive or combative to personal and other care, intimidating/threatening, or sexual acting out or exploitation) or inappropriate or unsafe behavior (including disrobing in public, eating non-edible substances, fire setting, unsafe cooking or smoking, wandering, elopement, or getting lost).

QUESTION ON PAE: Does applicant require persistent intervention for an established and persistent pattern of behavioral problems not primarily related to a mental health or substance abuse disorder?

HELPFUL HINT: Notice answers are in reverse from previous options, "Always" referring to the person requires intervention. An example may be the applicant needs someone to intervene daily when he/she attempts to strike their caregiver.

MARK THE ACCURATE ANSWER:

- Always: Applicant always requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 7 days per week.
- Usually: Applicant requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 4-6 days per week.

- Usually Not: Applicant requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 1-3 days per week.
- Never: Applicant never requires persistent intervention due to an established and persistent pattern of behavioral problems.

When the above question is answered with an **A** (Always) or **U** (Usually), you must document and specify, on the PAE, the behavioral problems requiring continual staff or caregiver intervention.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific behaviors and the frequency of such behaviors.

Recommended documentation to support this functional deficit: H&P, Plan of Care, nurse's notes, psych notes

5.11 SKILLED NURSING AND REHABILITATIVE SERVICES

For any applicant who requires one or more of the specified skilled nursing or rehabilitative services and at a frequency (daily for each of the specified skilled services and at least five (5) days per week for each of the specified rehabilitative services) for which level 2 NF reimbursement may be approved by TennCare, the submitter should complete the applicable portions of the PAE and attach documentation required for the determination of medical eligibility for level 2 or enhanced respiratory care reimbursement (as applicable), regardless of whether the applicant's care will be provided in a NF or in the community.

A Physician's Order will not be required if the skilled or rehabilitative services are being performed by a family member under a specified exemption to the Nurse Practice Act. However, the request must include medical records sufficient to document the need for each skilled or rehabilitative service(s), including the frequency of each service, as would be required for determination of eligibility of a higher level of NF reimbursement. This information will be used for purposes of determining the applicant's total acuity score (regardless of setting), as well as the applicant's cost neutrality cap if enrolled in CHOICES Group 2.

Reimbursement for Level 2 Nursing Facility Services requires specific supporting documentation for approval. This information is available in The PAE Tracking System as you complete this section of the PAE application (attached F). TennCare does not provide reimbursement for rehabilitative services for chronic conditions, exacerbations of chronic conditions, or weakness after hospitalization. Rehabilitative services for maintenance of functional status (e.g., routine range of motion exercises, stand-by assistance during ambulation, or applications of splints/braces) are not considered skilled level services.

While completing your assessment of the applicant preparing to complete the PAE, ensure you compile the appropriate documentation for submission if requesting reimbursement for The Skilled and/ or Rehabilitative services listed below:

- Wound Care for Stage 3 or 4 decubitus
- Other Wound Care (i.e., infected or dehisced wounds)
- Injections, sliding scale insulin
- Injections, other: IV, IM
- Intravenous fluid administration
- Isolation precautions
- *Occupational Therapy by OT or OT assistant
- *Physical Therapy by PT or PT assistant
- Teaching Catheter/Ostomy care
- Teaching self-injection
- Total Parenteral nutrition
- Tube feeding, enteral
- Peritoneal Dialysis
- Patient Controlled Analgesia (PCA) Pump
- New tracheostomy or old tracheostomy requiring suctioning through the tracheostomy multiple times per day at less frequent intervals, i.e., < every 4 hours

5.12 ENHANCED RESPIRATORY CARE

NOTE: Reimbursement for NF services at the CV rate can be made *only* to NFs that meet standards of care for delivery of ventilator services, as set forth in TennCare Rules.

In addition to the need for skilled and rehabilitative services counting as part of the total acuity score, NFs use the PAE to serve as authorization for meeting criteria to receive enhanced respiratory care reimbursement.

Reimbursement for Enhanced Respiratory Care rates (and an HCBS Cost Neutrality Cap based on eligibility for such enhanced level of reimbursement) is limited to persons who meet specified medical eligibility criteria below. Approval of Chronic Ventilator (CV) or Tracheal Suctioning (TS) reimbursement (or a Cost Neutrality Cap based on eligibility for such enhanced level of reimbursement) requires specific supporting documentation. The required supporting documentation is specified below for each rate. Documentation requirements may be modified for purposes of a Cost Neutrality Cap Determination, *as noted in italics below*. The specified

documentation must be submitted with the PAE and/or Cost Neutrality Determination, as applicable.

While completing your assessment of the applicant preparing to complete the PAE, ensure you compile the appropriate documentation for submission if requesting reimbursement for either chronic ventilator services and/or frequent tracheal suctioning (secretion management).

Chronic Ventilator Services – Provide all the following:

1. Chronic Ventilator reimbursement -the applicant must be ventilator dependent at least 12 hours per day or the use of a Non-Invasive Positive Pressure Ventilation (NIPPV) to delay tracheostomy for progressive neurological disorders.
2. A physician’s order for ventilator care *(For Cost Neutrality, submit the physician’s order for nursing services.)*
3. A detailed treatment plan developed with input and participation from a pulmonologist or other licensed professional with experience in ventilator care signed by the treating physician or a licensed respiratory care practitioner who will oversee the ventilator care *(For Cost Neutrality, submit the care plan for home-based nursing services.)*

Frequent Tracheal Suctioning (Secretion Management) –In order to be approved for this level of reimbursement the applicant must have a functioning tracheostomy and have a copious volume of secretions (defined as 25-30cc per day). Secretion Management (invasive tracheal suctioning) is one of 2 options; the second is the use of mechanical airway clearance devices and/or heated high flow molecular humidification via the trach at a minimum of 3 times per day.

1. A physician’s order for tracheal suctioning *(For Cost Neutrality, submit the physician’s order for nursing services to perform tracheal suctioning.)*
2. A detailed treatment plan signed by the treating physician, licensed registered nurse, or licensed respiratory professional who will oversee the intensive respiratory care *(For Cost Neutrality, submit the care plan for home based nursing services to perform tracheal suctioning.)*
3. *If some of the care is performed by family members or other caregivers, submit detailed documentation of the care provided by family members or other caregivers, in addition to physician’s orders and a nursing care plan for services performed by a registered or licensed nurse.*

NOTE: The NF must ensure the availability of necessary equipment, supplies, and appropriately trained and licensed nurses or licensed respiratory care practitioners to perform the specified tasks.

5.13 FINALIZING THE FUNCTIONAL ASSESSMENT

Now that you have performed the assessment, you should thoroughly review all the medical documentation you've gathered to support each assessment. This is to ensure documentation is complete and there are no areas of question; all discrepancies should have been remediated during the assessment process. If there are pieces of conflicting information, those areas should be clarified by obtaining additional documentation. Once you have clear and concise information you will assimilate the information in preparation of submitting the PAE in The PAE Tracking System, and if needed, the safety determination request. For every response you mark on each assessment performed, ask yourself the question, "Does my documentation support this response?" If the answer is no, then chances are that TennCare will have the same questions.

5.14 SAFETY DETERMINATIONS

A safety determination is defined in TennCare Rule as a TennCare decision regarding whether an applicant would qualify to enroll in CHOICES Group 3 or if there is sufficient evidence to demonstrate that the necessary intervention and supervision needed by the applicant cannot be safely provided within the array of services and supports that would be available if the Applicant was enrolled in Choices Group 3.

The need for inpatient care requirement of NF LOC may be satisfied with either a total acuity score of 9 or a determination that a person who meets "At Risk" LOC does not qualify for enrollment into CHOICES Group 3. A submitting entity may demonstrate on the PAE application that a person does not qualify for enrollment into CHOICES Group 3 because he/she cannot be safely served using the full array of benefits and services available. A safety determination request can also be made upon the request of the applicant or the applicant's representative. In these cases, the submitting entity indicates the request is made by the applicant and/or family member, on the safety determination form and in the PAE Tracking System. Complete information regarding criteria for a Safety Determination Request and the process for submission can be found in Chapter 7.7.

5.15 DOCUMENTATION TO SUPPORT THE NF PAE

All PAE submissions are required to have specific supportive documentation reflecting the deficits as identified on the PAE. This documentation will be reviewed by TennCare and

compared to the PAE and functional deficits as listed when determining LOC. If supportive documentation is not attached to the PAE according to specifications, LOC may be denied.

The following are required attachments to a NF PAE submission:

- A recent History and Physical (completed within 365 days of the PAE Request Date) OR other recent medical records from a medical professional who provided the medical diagnoses which support the applicant's functional and/or skilled nursing or rehabilitative needs;
- MD certification of medical necessity is required for NF PAE submissions;
- Certification of the accuracy of the PAE shall be required for all PAEs;
- Current Physician's Orders for NF service and/or level of NF reimbursement requested (as applicable); and
- Supporting documentation for reimbursement of skilled nursing and/or rehabilitative services based on the need for such services.

Reminder: While an appropriate PASRR is not a required attachment, the entire PASRR process is required to be completed before a NF LOC determination can be made for Group 1 requests. In the event there has been an appropriate change of status (COS) completed, that determination should be added as an attachment to the PAE and labeled as Change of Status to satisfy the PASRR requirement.

Complete information regarding PAE Documentation is in Chapter 14.

5.16 NF LOC PAE SUBMISSION

When a NF PAE *should* be submitted

A NF PAE should be submitted when:

1. A TennCare eligible person is admitted to a NF for receipt of TennCare reimbursed NF Services
2. A private-paying resident of a NF attains TennCare eligible status
3. A NF eligible person requires continuation of the same LOC beyond a PAE expiration date assigned by TennCare
4. A person is applying for CHOICES or PACE

When a PAE *must* be submitted

A PAE must be submitted anytime there is a change in LOC when:

1. Medicare reimbursement for SNF (Skilled Nursing Facility) services has ended

- and TennCare skilled services (Level 2) reimbursement for NF services is requested
2. An NF eligible person has a change in LOC such as a change from TennCare Level 1 (ICF) to TennCare skilled services (Level 2) reimbursement, or from TennCare Level 1 (ICF) or Enhanced Respiratory Rate (ERC) reimbursement to a Chronic Ventilator or Tracheal Suctioning Enhanced Respiratory Care rate, Enhanced Respiratory Care rate to TennCare Level 1 (ICF) reimbursement, unless the person already has an approved unexpired Level 1 PAE
 3. An NF eligible person is changed from an Enhanced Respiratory Care (ERC) rate to TennCare skilled services (Level 2) reimbursement, unless the person has an approved unexpired Level 2 PAE
 4. An NF eligible person no longer requires the specific skilled nursing or rehabilitative services for which a skilled service (Level 2) PAE was approved but requires other skilled nursing or rehabilitative services for which skilled services (Level 2) reimbursement may be authorized in a NF
 5. A member enrolled in CHOICES Group 1 or Group 2 no longer meets NF LOC (in place at time of enrollment)

When a PAE is not required

A PAE is not required:

1. When an NF Eligible person with an approved unexpired Level 1 PAE returns to the NF after being hospitalized
2. When an NF Eligible person with an approved unexpired Level 2 PAE returns to the NF after being hospitalized, if there has been no change in the skilled nursing or rehabilitative service for which the PAE was approved
3. When a NF Eligible person changes from Level 2 to Level 1 NF reimbursement and has an approved unexpired Level 1 PAE
4. To receive Medicaid co-payment when Medicare is the primary payer of SNF care
5. When a Discharge/Transfer/Hospice Form is appropriate.
6. For authorization by an MCO of Ventilator Weaning services or short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention. Medical necessity determinations and authorization of Ventilator Weaning services and short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate during the post-weaning period will be managed by the person's MCO
7. When a person will be receiving hospice services in the NF.

5.17 MD CERTIFICATION FOR NF REQUESTS

For NF applicants, the medical necessity provision of NF LOC is satisfied through Physician, MD or DO (or PA, NP, APN as applicable) signature and printed name on the PAE certification form (Attachment C).

- This form can also be printed from the homepage of The PAE Tracking System online portal.
- It is important to use the most recently updated form for the PAE submission be an original physician's signature is required when submitting a PAE and any revisions or recertifications.
- PAEs will not be approved for NF LOC unless the certification form is filled out in its entirety and the physician, MD or DO (or PA, NP, APN as applicable) has signed the statement on the PAE Certification page certifying the applicant requires the level of care provided in a nursing facility and that the requested long term care services are medically necessary for the applicant.
- The information on the certification page must match that provided in the certification tab in The PAE Tracking System.
- Anytime, it appears that a Certification Signature is duplicated or not an original signature, a referral to TennCare's Program Integrity Unit must be made.

5.18 NF SPECIFIC DOCUMENTATION IN THE PAE TRACKING SYSTEM

Service Requested

Check the box identifying the appropriate service that the applicant requests. If the applicant is choosing to admit into a nursing facility, choose "Nursing Facility".

Nursing Facility Choices

- Check the box identifying the appropriate Reimbursement Levels to the applicant's service needs:
 - Level 1: would qualify for Level 1 NF care
 - Level 2: would qualify for Level 2 (or skilled) SNF care
 - CV would qualify for enhanced respiratory care (i.e., for persons who are chronically ventilator dependent).
 - TS (Tracheal Suctioning) Secretion Management: would qualify for enhanced respiratory care (i.e., for persons who have a

functioning tracheotomy that requires frequent suctioning through the tracheotomy as described in Enhanced Respiratory Care Chapter 10).

- Check the box identifying the appropriate Submission Request Type for the PAE:
 - New CHOICES applicant: a person who is currently not a CHOICES member
 - Change in current LOC: a person who is a current CHOICES member and his/her level of care needs have changed in any manner such that it is not reflected on the current PAE
 - Current CHOICES member, current PAE ending: a person who is a current CHOICES member and his/her PAE is soon to end and the requestor believes CHOICES should continue
 - Hospice: Hospice services are not Long Term Services or supports and do not require a PAE. If the service type being requested is hospice, please stop and do NOT submit the PAE.

Applicant Admitted From

If the applicant has been admitted into a nursing facility, check the box identifying the location that the applicant resided prior to admission; another nursing facility, home, hospice care, or hospital.

Applicant currently resides in a NF

Answer the question Yes or No. If yes, document the date of admission to that facility. If available, document the facility Medicaid Provider number.

Discharge Expectation

Check the box identifying if the applicant is expected to discharge from the facility within the next six (6) months or not expected to discharge. This indication may affect decisions related to estate recovery and PAE approval effective dates.

Diagnosis

Enter the full diagnosis that is relevant to the applicant's functional and/or skilled nursing needs. This diagnosis should also be found within the supporting documentation that is attached to the PAE.

Entering the PAE Request Date

This is the date you want the PAE to be effective. As part of the PAE approval process, TennCare will determine the PAE approval effective date and will use what you enter as part of their decision. Please see Chapter 15 to learn more about how TennCare determines a PAE approval effective date.

Nursing Facility, Address/Phone Number(s)

Enter the full name of the nursing facility that the applicant is requesting for admission or a current resident of. Enter the facility's phone number including area code. Enter the full address of the facility including City, State, County and Zip Code.

Current NF payer source

Check the box identifying the current nursing facility payer source at the time of the PAE; Medicare or Private Pay (if other, please note).

Medicaid Only Payer Date

Enter the requested date of Medicaid payment for NF services (otherwise known as the **Medicaid Only Payer Date** or MOPD) if known at the time of the PAE submission. If the MOPD is unknown, the PAE will be processed and level of care determined. However, an MOPD is required before CHOICES enrollment can be approved. It is very common for facilities to submit a PAE then enter the MOPD at a later time once it is known. The PAE Tracking System home page includes a list of items waiting for an MOPD to be entered.

- The Medicaid Only Payer Date or MOPD is required before a person is enrolled into CHOICES Group 1/NF LOC.
- In addition to other CHOICES enrollment requirements, the Bureau of TennCare must have received notification from the NF that Medicaid reimbursement is being requested for the effective date of CHOICES enrollment.
- The MOPD is the date the NF intends to bill the MCO (CHOICES) for NF services because no other payer source exists. Other payers include third party liability such as private insurance or Medicare. It also means that the patient is not privately paying.

**This requirement is cited in [TennCare Rule 1200-13-01-.02](#).*

The MOPD is a known date; it's not a guess or an estimate. This means that the MOPD should not change once entered in TPAES. If a MOPD does change, the MCO must be contacted. Sometimes the MOPD is known at the time the PAE is submitted. Sometimes the MOPD is not known until more information is gathered about other payer sources. A NF can enter the MOPD at any time; there is no time limit. However, if there is more than 90 days between the PAE approved effective date and the Medicaid Only Payer Date a facility must recertify the PAE.

If there is more than 365 days between the PAE approved effective date and the Medicaid Only Payer Date a facility must submit a new PAE.

MOPD and Exhaustion of Medicare Benefits

If applicant does NOT currently reside in a NF and/or Medicare is responsible for NF payment, applicant cannot be enrolled into CHOICES Group 1, even if a PAE is approved. Upon NF admission and/or exhaustion of Medicare benefit, the NF must via the PAE Tracking System enter a Medicaid Only Payer Date (MOPD) before enrollment into CHOICES can occur.

PASRR Level II Process Admit Date

If Medical Eligibility was determined through the PASRR Level II process, it is not necessary to enter a MOPD. It is, however necessary to populate an admit date into Path tracker as this is the alternate way to alert to TennCare to the date you wish for Group 1 enrollment to occur.

Submission of NF PAE Certification

NF PAE submissions require that the information on the certification form must match the information provided on the certification tab in the PAE Tracking System. This must include the Physician certification on both the Certification form and tab. For all PAE submissions (PACE, NF, or HCBS), regardless of the PAE submitter, the name and credentials of the individual who conducted the face-to-face assessment of the applicant must be reflected on the Certification tab in the PAE Tracking System. Upload and attach the Certification form to the NF or PACE PAE prior to submitting to TennCare.

5.19 NF REIMSUBRSEMENT

HOSPICE CARE

Hospice is covered under the TennCare program as a medical benefit, not a long-term care benefit. When a person elects to receive hospice in a NF, federal regulations require that room and board in the NF is reimbursed by the hospice facility as part of the hospice benefit. So, when a NF resident elects hospice, he/she continues to reside in the NF and to receive appropriate room and board, as well as other services. However, these services are reimbursed to the NF by the hospice agency as a part of the hospice benefit, and not by the MCO as LTSS are no longer being provided. A PASRR is required for person's admitting to a Medicaid certified nursing facility regardless of payer source. The one caveat is if the institution has distinct parts that are not Medicaid certified.

NF Care without an Approved PAE

Also keep in mind that in accordance with TennCare Rule 1200-13-01-.10 (d) if a NF admits or

allows continued stay of a TennCare Eligible without an approved PAE it does so at its own risk and in such event the NF shall give the applicant a plain language written notice that Medicaid reimbursement will not be paid unless the PAE is approved and if it is not finally approved the applicant can be held financially liable for services provided, including services delivered prior to the effective date of the PAE and enrollment in CHOICES Group 1, unless a third party is liable.

Skilled Services (LEVEL 2) NF REIMBURSEMENTS

To qualify for the approval of skilled services (Level 2) reimbursement, the applicant must have a physical or mental condition, disability, or impairment that requires one or more of the skilled nursing or rehabilitative services for which skilled services (Level 2) NF reimbursement may be authorized by TennCare. The need for such service must be supported by the medical evidence submitted with the PAE.

The individual must require such services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit. The applicant must require the skilled service on a daily basis and/or the rehabilitative service at least five (5) days per week, pursuant to a physician's order.

In addition, the individual must be mentally or physically unable to perform the needed skilled services or the individual must require skilled services which, in accordance with accepted medical practice, are not usually and customarily self-performed.

- a. Administration of oral medications, ophthalmics, otics, inhalers, subcutaneous injections (e.g., fixed-dose insulin, sub-therapeutic heparin, and calcitonin), topicals, suppositories, nebulizer treatments, oxygen administration, does not satisfy this requirement.
- b. Nursing observation and assessment do not satisfy this requirement.

A skilled rehabilitative service must be expected to improve the individual's condition. Restorative and maintenance nursing procedures (e.g., routine range of motion exercises; stand-by assistance during ambulation; applications of splints/braces by nurses and nurse aides) do not satisfy this requirement.

Skilled/ERC Reimbursement Request Extensions

Skilled/ERC reimbursement requests initially determined through PASRR may be extended by submitting a new "mirror" PAE via the PAE Tracking System. Skilled/ERC reimbursement requests

may be extended by requesting “extend skilled service” in the PAE Tracking System by uploading current documentation of the service request and adding a new certification page (NF only). These requests may not be submitted more than 5-8 business days of the previous end date. If LOC is determined through the PASRR process a PAE may be submitted via the PAE Tracking System in order to extend skilled/ERC services.

5.20 RECERTIFYING A CHOICES NF PAE

The purpose of recertifying a CHOICES PAE is to demonstrate that information submitted on the PAE is still accurate, even though the PAE has not been used for a period of 90 days or more. PAEs do **NOT** need to be recertified every 90 days. However, if you have submitted a PAE and there is more than 90 days between the PAE approval date and the MOPD, the PAE must be recertified to show that the individual continues to meet the level of care represented on the initially submitted and approved PAE. Essentially recertification is a signed statement from the treating physician, MD or DO (PA, APN, or NP as applicable) verifying that the PAE application submitted still accurately represents the needs of the applicant. The PAE Certification Form recertification includes this statement: “I certify that the applicant’s medical condition on the recertified PAE is consistent with that described in the initial certification and that Nursing Facility services are medically necessary for the applicant.”

When a user enters the MOPD on a PAE and it is more than 90 days from the PAE approval effective date, the PAE Tracking System will prompt the user to recertify the PAE. This is the only time a PAE needs to be recertified. A PAE with no end date can be recertified anytime within 365 days of the initial submission. A PAE with an end date can be recertified, but recertification will never extend a PAE expiration date. A new PAE is required to extend an end dated PAE.

If the applicant’s medical condition has changed significantly, such that the previously approved PAE does not reasonably reflect the applicant’s current medical condition and functional capabilities, a new PAE is required.

When a PAE is recertified, the original PAE Certification form must be submitted with the recertification portion filled out.

5.21 NF APPEALS

NF DISCHARGE REQUIREMENTS UNDER THE *DOE* CONSENT DECREE

In accordance with Section 5(a)(2) of the *Doe v. Word* Consent Decree, whenever a current resident of a nursing home has submitted a PAE for approval of Medicaid reimbursement for NF

services, the resident may not be discharged because TennCare initially denied the PAE application until any appeal is resolved or the time during which an appeal may be requested has passed without action. This includes an applicant denied for NF level of care, but approved for “At Risk” LOC.

Once a NF has determined that an appeal has not been filed, and that the time limit for appealing a PAE with TennCare has expired, federally compliant discharge processes may continue. Federal requirements pertaining to NF Discharge and transfer processes can be found at 42 CFR 483.12. A copy of the *Doe v. Word* Order can be found on the TennCare website.

NF REQUEST FOR INFORMATION PROCESS

TennCare has a process to request the immediate attention of a NF when a PAE has been denied, providing 10 calendar days for a NF to submit additional documentation which, if submitted and determined sufficient to approve NF level of care, would preserve the original PAE effective date. Only when the NF *again* fails to submit information sufficient to remedy the deficiencies with the PAE would any subsequent approval date, including approval during the pendency of an appeal, be based on the later date that the deficiency is finally cured.

6.0 HOME COMMUNITY BASED SERVICES (HCBS)—CHOICES Group 2

CHOICES is TennCare’s program for long-term care services and supports for the elderly (65 years of age and older) and disabled (21 years of age and older). Long-term care includes help doing everyday activities that a person may no longer be able to do for himself as he grows older, or because of a physical disability. CHOICES services include care in a nursing home and certain services to help a person remain at home or in the community. These are called **Home and Community Based Services** or **HCBS**. CHOICES is a managed LTSS program with services offered through TennCare **Managed Care Organizations (MCO)** under contract with TennCare. There are three (3) MCOs: Amerigroup, BlueCare and United HealthCare Community Plan. The MCOs are responsible for coordinating all covered physical, behavioral and LTSS for members who qualify for and are enrolled in CHOICES.

There are three groups in CHOICES. Participation in CHOICES Group 1 is limited to TennCare members who qualify for and are receiving TennCare-reimbursed **Nursing Facility (NF)** services.

Participation in CHOICES Groups 2 and 3 is limited to TennCare members who qualify for and are receiving TennCare-reimbursed HCBS.

For HCBS applicants who are already Medicaid eligible at the time of CHOICES referral, MCOs perform intake functions, including completion and submission of the PAE to TennCare. MCO may also assist NF applicants who are already enrolled in Medicaid.

This chapter provides information and guidance to facilitate the assessment or data collection, decision making, and PAE submission necessary for CHOICES Group 2. ***These individuals meet Nursing Facility Level of Care criteria but choose to have TennCare-reimbursed Home Community Based Services.***

6.1 MEDICAL NECESSITY OF CARE FOR HCBS CHOICES GROUP 2

Care is not provided in a Nursing Facility, but instead in the home or community setting. Rather than being *expected to improve or ameliorate the individual's physical or mental condition, to prevent deterioration in health status, or to delay progression of a disease or disability*, the purpose of HCBS is primarily to allow the person to continue living safely in the community and to delay or prevent placement in a NF.

And, While HCBS do not require a Physician's Order, such services:

- must be specified in an approved plan of care,
- must be needed by the individual *on an ongoing basis*.
- to satisfy medical necessity of care requirements for HCBS, it must be determined that HCBS must be required in order to allow the person to continue living safely in the home or community-based setting and to prevent or delay placement in a nursing facility, and such HCBS must be specified in an approved plan of care and needed *on an ongoing basis*.

The need for one-time HCBS is not sufficient to meet medical necessity of care. And, if a person's ongoing need for assistance with activities of daily living and/or instrumental activities of daily living can be met through the receipt of services available to the member through community resources (e.g., Meals on Wheels) or other payer sources (e.g., Medicare), the person does not require HCBS in order to continue living safely in the home and community-based setting and to prevent or delay placement in a nursing facility.

6.2 NEED FOR INPATIENT CARE FOR PERSONS ELIGIBLE FOR NF CARE WHO ELECT CHOICES HCBS

Persons receiving Group 2 HCBS must have a physical or mental condition, disability or impairment (as determined by the functional assessment on the PAE). Such impairment does not necessarily require daily inpatient nursing care, but instead, must require ongoing supervision and assistance with activities of daily living in the home or community setting. While services do not have to be required on a *daily* basis, the need for assistance must be **ongoing** such that the person would otherwise require placement in a NF.

The individual must be unable to self-care and must:

- Have a total acuity score of at least 9 on the TennCare NF LOC Acuity Scale; or
- Meet at risk LOC (described below) on an **ongoing basis and** be determined by TennCare to not qualify for enrollment in CHOICES Group 3 based on a Safety Determination.

6.3 REQUEST FOR HCBS GROUP 2 IN THE PAE TRACKING SYSTEM

Applications for Individuals desiring CHOICES Group 2 HCBS, must be documented in The PAE Tracking System. For AAAD's this is completed by checking the ongoing HCBS field and for MCOs this is captured through completion of the Cost Neutrality Tab. For individuals applying for PACE, physician certification of level of care and medical necessity is required.

6.4 LOC ACUITY SCALE

Individuals in HCBS CHOICES Group 2 meet the same LOC as individuals in NF LOC CHOICES Group 1. Those in HCBS CHOICES Group 2 have elected to receive care at home or in the community.

The total acuity score is calculated using the assessment of certain functional and clinical needs. The clinical needs as captured on the PAE are skilled and/or rehabilitative services (e.g., tube feeding, wound care, occupational therapy, physical therapy, ventilator care). The functional needs as captured on the PAE include the applicant's need for assistance with the following Activities of Daily Living (ADLs):

- Transfer;
- Mobility;
- Eating; and
- Toileting;

And deficits in the following ADL-related functions:

- Communication (expressive and receptive);
- Orientation (to person, place, or event/situation);
- Behaviors; and
- Self-administration of medications

The TennCare NF LOC Acuity Scale is attached. (Attachment A)

6.5 QUALIFICATIONS FOR ENROLLMENT IN HCBS LOC GROUP 2

1. An applicant must have an approved, unexpired PAE for NF LOC;
2. An applicant must be approved financially for TennCare reimbursement of LTSS as an SSI recipient or in an institutional category (i.e., as Members of the CHOICES 217-Like demonstration population);
3. An applicant must be in the target population;
4. TennCare must have received a determination by the MCO or AAAD that the applicant's needs can be safely and appropriately met in the community, and at a cost that does not exceed the Individual Cost Neutrality Cap; (see Chapter 10) and
5. There must be capacity within the established Enrollment Target to enroll the applicant.

6.6 DETERMINING AN INDIVIDUAL'S COST NEUTRALITY CAP (CN) FOR CHOICES GROUP 2

When CHOICES Group 2 requests are received and NF LOC is approved, the PAE reviewer must determine the individual's cost neutrality cap. The cost neutrality cap is defined as: the average cost of the level of NF reimbursement that would be paid if the member were institutionalized. The level of reimbursement that would be approved for a Group 1 request is the cost neutrality cap for a group 2 request.

- A member who would qualify only for Level 1 NF reimbursement has a cost neutrality cap set at the average cost of Level 1 NF care.
- A member who would qualify for Level 2 NF reimbursement has a cost neutrality cap set at the average cost of Level 2 or skilled NF care.
- A member who would qualify for the Enhanced Respiratory Care Reimbursement for persons who are chronically ventilator dependent or for persons who have a functioning tracheostomy that requires frequent suctioning through the tracheostomy will have a cost neutrality cap that reflects the higher payment that would be made to the NF for such care.
- There is no cost neutrality cap for Ventilator Weaning Reimbursement as such service is available only on a short-term basis in a SNF or acute care setting (not HCBS).

6.7 HCBS CHOICES GROUP 2 TRANSITIONS

Transition from CHOICES Group 1 to Group 2

An MCO may request to transition a member from Group 1 to Group 2 only when the member chooses to transition from the NF to a home and community based setting. Members shall not be required to transition from Group 1 to Group 2. Only an MCO may submit to TennCare a request to transition a CHOICES member from Group 1 to Group 2. A member that has already been discharged from the NF shall not be transitioned to CHOICES Group 2. Once a member has been discharged from the NF, he/she has voluntarily dis-enrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 2. A new HCBS PAE shall be required for enrollment into CHOICES Group 2. When members move from Group 1 to Group 2, TennCare Member Services must recalculate the member's Patient Liability.

Transition from CHOICES Group 2 to Group 1:

An MCO may also request to transition a member from Group 2 to Group 1 only if the member meets NF LOC criteria, has completed the PASRR process, a physician ordered NF care and the member is found to be NF appropriate, and at least one (1) of the following is true:

- (i) The member chooses to transition from HCBS to NF. Examples include a decline in the member's health or functional status or a change in the Member's natural care giving supports; or
- (ii) The MCO has made a determination that the member's needs can no longer be safely met in the community and at a cost that does not exceed the average cost of NF services for which the member would qualify, and the member chooses to transition to the more appropriate institutional setting in order to safely meet his/her needs.

When members move from Group 2 to Group 1, TennCare member Services must recalculate the member's Patient Liability.

Transition from CHOICES Group 1 or Group 2 to Group 3:

TennCare or the MCO shall, subject to eligibility and enrollment criteria, initiate a transition from Group 1 or 2 to Group 3 when a member who was enrolled in CHOICES Group 1 or Group 2 on or after July 1, 2012 no longer meets NF LOC but meets "At Risk" LOC. A member that has already been discharged from the NF shall not be transitioned from CHOICES Group 1 to CHOICES Group 3. Once a Member has discharged from the NF, he has voluntarily dis-enrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 3. In these instances, the member must qualify for SSI at the time of transition and a new HCBS PAE shall be required for enrollment into CHOICES Group 3.

Transition from CHOICES Group 3 to Group 1 or Group 2:

TennCare or the MCO shall initiate a transition from Group 3 to Group 1 or Group 2, as

appropriate, when the member meets NF LOC and satisfies all requirements for enrollment into the requested Group. When a member transitions from Group 3 to Group 1, TennCare Member Services must recalculate the member's Patient Liability.

Transitions Based on Safety:

For existing CHOICES members, assessments are completed by the MCO annually and upon a change of the member's status/ condition. If at any time the MCO determines that the member's needs can no longer be safely met in the current care setting, the MCO may initiate and submit to TennCare a request for a safety determination as described in TennCare Rule. This determination must be made considering all covered services and supports available within either the individual's cost neutrality cap for Group 2 members.

TennCare must approve the MCO's request to transition due to safety and/or cost neutrality once the requirements for transition have been met. If a member does not wish to transition to another CHOICES Group so that his needs can be safely met, the MCO may initiate CHOICES disenrollment proceedings.

6.8 CHOICES GROUP 2 HCBS PAE ASSESSMENTS

Now that you are familiar with CHOICES and have an understanding of eligibility and enrollment criteria, we will introduce the process for completing a PAE application so that TennCare may determine level of care and medical eligibility, for CHOICES and PACE. Remember, for an applicant to qualify for CHOICES Group 2 or PACE, the NF LOC must be approved. This section will walk you through preliminary assessment information necessary to conduct assessments for CHOICES HCBS Group 2 and PACE applicants.

WHO CAN COMPLETE A HCBS ASSESSMENT?

HCBS PAEs, assessors are clinically trained staff (employed by a PACE Organization, MCO or AAAD) who have completed an in person TennCare training about LTSS Programs and the HCBS PAE application process. The assessor must be a Physician (MD or DO), Physician Assistant (PA), Nurse Practitioner (NP), Advanced Practice Nurse (APN), Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Social Worker (LSW). Additionally, HCBS assessors must be TennCare Qualified Assessors.

Additionally, TennCare Qualified Assessors for HCBS must take and pass a test measuring their understanding of HCBS requirements and renew their qualified Assessor status annually. Qualified Assessors are assigned a unique Qualified Assessor Code. This code must be documented on the PAE with the Assessor Certification signature. TennCare will only accept HCBS PAE assessments performed by individuals who have been deemed a HCBS Qualified Assessor (regardless of TPAES submitter). HCBS Qualified Assessor trainings are offered by TennCare on a regular basis.

HCBS GROUP 2 PAE CERTIFICATION

The clinical assessor must certify that the level of care information provided on the PAE is accurate. Assessors must also acknowledge that they understand that the information provided is being used to determine Medicaid eligibility and/or reimbursement for long-term services and supports and that any intentional act to provide false information that would potentially result in a person obtaining benefits or coverage that he or she is not entitled to is considered an act of fraud under the State's TennCare program and Title XIX of the Social Security Act. This certification is captured in The PAE Tracking System on the Certification Tab. The PAE Certification Form is signed and dated by the LOC certifier and is included with the PAE application as an attachment in The PAE Tracking System. Sometimes a physician, PA, NP, APN RN, LPN LSW, or TennCare Qualified Assessor allows a PAE to be completed and submitted in The PAE Tracking System by someone else on his/her behalf. In these cases, the physician, PA, NP, APN, RN, LPN, LSW, or TennCare Qualified Assessor continues to assume all responsibility for ensuring that the information as submitted is accurate.

INTERVIEWING PROCESS FOR AN HCBS PAE

TennCare has provided applicant and collateral interview tools to assist with the PAE application process to help paint a clear picture of the applicant and assistance they require. These tools are not a requirement, but it is recommended they be utilized along with supporting medical documentation.

The preferred source of information is the client. If there is another person in the room when the client is being interviewed, questions should continue to be directed to the client. If others who are present try to answer questions for the client, they should be asked not to assist with responses or provide reminders or hints. They will be given the opportunity to complete their own interview.

Other sources of information, such as the primary caregiver, family members, other helpers, friends, neighbors and/or provider staff should also be used. For the completion of some sections of the assessment, the assessor may need to interview other professional staff such as physicians, nurses, or social workers. Also, it may be necessary to obtain a translator or some other spokesperson for the individual. It will be important to know ahead of time if possible, to prepare for the interview beforehand.

Although it is recommended, it is not necessary to seek information in the exact order in which appears on the form. The form is designed with a logical flow and is intended to appear reasonable to the applicant. However, because applicants will present information in their own way, it is not necessary to ask questions which have already been answered in the course of the interview, just record the answer already given.

ASKING QUESTIONS FOR AN HCBS PAE

A good clinical interviewer is always on the lookout for both themes and discrepancies. Themes help you note and describe patterns across time. These patterns may be critical to understanding both how to leverage the person's strengths and to understand how best to support the person to prevent patterns of difficulties. An assessor should never lead the respondents toward a particular answer but is encouraged to ask for descriptions and clarifications that will help the respondent or the assessor to resolve discrepancies or inconsistencies in the information being received. Being alert for discrepancies to conflicting reports ensures that the assessor gets clarification to clarify promptly when information just doesn't add up.

It is important that the assessor avoids using "buzz words", generalizations, or reporting opinions instead of descriptions and observations. Provide objective, extensive and clear descriptions of the person's medical, functional and behavioral status. When describing behavioral symptoms, remember that the same behavioral symptoms can present very differently for each person. One person's experience of "agitated" can involve violent or aggressive behaviors, while another person's experience may involve irritability, lack of sleep and extreme restlessness. It is important to describe in detail what behaviors, support needs, etc. look like for that person. Tell the story of their current presentation.

Ensure the assessment form provides a clear, detailed and consistent picture of the individual's functional status.

The best guidance for a great clinical interview is to collect individualized, detailed information from a variety of sources to ensure that the individual's unique needs and characteristics are reflected. The quality of this process is directly correlated to the quality of the clinical interview.

6.9 FUNCTIONAL ASSESSMENT

Now that you understand who can perform assessments it's important for all submitters to understand how to complete the functional assessment on the PAE. Remember, there are two components of level of care (LOC) eligibility:

- Medical necessity of care; and
- Need for inpatient care.

Both components apply to Nursing Facility LOC and At Risk LOC. The functional assessment and supporting medical evidence included with the PAE application is used to determine if the Need for Inpatient Care requirement is satisfied when determining LOC.

First, we'll walk through how to measure levels of functional deficit on the PAE. Next, we'll cover each functional area and the applicant's need for assistance. Then we'll explain how the need for skilled and/or rehabilitative services is documented on the PAE.

Measuring Functional Deficits

On the PAE, there are 4 possible responses to each question. *Except* for behavior, "**Always**" means that the applicant is **always independent** with that ADL or related activity. "**Usually**" means that the person is **usually independent** (requiring assistance fewer than 4 days per week). "**Usually not**" means that the applicant is usually not independent (requiring assistance 4 or more days per week). "**Never**" means that the applicant is **never independent** with that ADL or related activity.

With respect to behavior, the responses are reversed. "**Always**" means that the applicant always requires intervention for behaviors. "**Usually**" means that the applicant requires intervention for behaviors 4 or more days per week. "**Usually not**" means that the applicant requires intervention for behaviors, but fewer than 4 days per week. "**Never**" means that the applicant does not have behaviors that require intervention.

TennCare has assigned a weighted value to each of the possible responses to each question on the PAE, based on the amount of assistance that would be required for a person with that type and level of ADL or related deficit. The TennCare NF LOC Acuity Scale (Attachment A) provides the weight given to each functional measure and response. Each response must be supported by the medical evidence submitted with the PAE for the assigned acuity score to be approved by TennCare.

ADLs and ADL-related functions

When providing responses to each functional measure as indicated on the functional assessment, you should consider the act of physical assistance being "hands on" care. You should also consider a person's functionality in a 24 hour/7 days a week window of need. Some patients may appear, during your presence, to be functioning well in an area that they may not function well at in different times/days. For example, someone may be only incontinent at night, but continent the rest of the day. When these types of situations exist, it is important to clearly explain it on the PAE as a note or comments in The PAE Tracking System.

I. Transfer

DEFINITION: Transfer - The applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis. **QUESTION ON PAE:** Can applicant transfer to and from bed, chair or toilet without physical help from others?

HELPFUL HINT: This is moving the body from one place to another without ambulating (which is covered under the Mobility section). It is important to note the definition applies to bed, chair, or toilet only. An example may be that the applicant needs someone to hold onto him to successfully get up/down from the bed and on/off the toilet.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of transfer to and from bed, chair, or toilet without physical assistance from others.
- Usually: Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of transfer to and from bed, chair, or toilet without physical assistance 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit requires documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of transfer assistance required.

Recommended documentation to support this functional deficit: medical History and Physical (H&P), ADL flow sheets, PT notes, nurse's notes, section "G" of Minimum Data Set (MDS)

II. Mobility

DEFINITION: Mobility - The applicant requires physical assistance from another person for mobility on an ongoing basis. Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair (manual or electric) if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

QUESTION ON PAE: Can applicant walk without physical help from others?

HELPFUL HINT: This is the act of moving from one place to another. In other words, if someone is able to get from one place to another using their manual or power wheelchair, this would be considered "mobile". An example may be that the applicant needs someone to hold on to him when he is ambulating with his cane.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of walking without physical assistance.
- Usually: Applicant is incapable of walking unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable walking unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of walking without physical assistance 7 days per week.

Only when the above question is answered with a **UN** (Usually Not) or **N** (Never), follow to the next question under Mobility:

QUESTION ON PAE: If walking is not feasible (answer to mobility question above is UN or N), is Applicant capable of using a wheelchair, either manual or electric?

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of mobility without physical assistance.
- Usually: Applicant is incapable of wheelchair mobility unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of wheelchair mobility unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of wheelchair mobility without physical assistance 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of mobility assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, PT notes, nurse's notes, section "G" of MDS

III. Eating

DEFINITION: Eating - The Applicant requires physical assistance with gastrostomy tube feedings or physical assistance or constant one-on-one observation and verbal assistance (reminding, encouraging to consume prepared food and drink or self-administer tube feedings, as applicable) or must be fed part or all of each meal. Food preparation, tray set-up, assistance in cutting up foods, and general supervision of multiple residents shall not be considered to meet this requirement.

QUESTION ON PAE: Can applicant eat (or physically self-administer tube feeding as applicable) without help from others?

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of eating without help from others.
- Usually: Applicant is incapable of eating without help from others 1-3 days per week.
- Usually Not: Applicant is incapable of eating without help from others 4-6 days per week.
- Never: Applicant is never capable of eating without help from others 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation which supports the need for such intervention, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task. For PAEs submitted by the AAAD (or entity other than an MCO, NF, or PACE Organization), an eating or feeding plan specifying the type, frequency and duration of supports required by the Applicant for feeding, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task shall be required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, OT/ST notes, nurse's notes, swallow study, section "G" of MDS

IV. Toileting

DEFINITION: Toileting - The applicant requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or catheter care on an ongoing basis

QUESTION ON THE PAE: Can applicant toilet without physical assistance from others?

HELPFUL HINT: Includes the act of toileting, adjusting clothing and/or being able to properly clean oneself. This does NOT include the act of getting on/off the toilet as this is accounted for in the Transfer question. Incontinence is scored separately, for example someone may usually be able to toilet but is incontinent and can never clean themselves. Some people can have an indwelling catheter and care for it themselves, do not assume the presence of one means the person is never able to self-care. An example may be the applicant needs someone to clean him/herself and help him/her pull up their pants and buckle their belt after toileting.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of toileting without physical assistance.
- Usually: Applicant is incapable of toileting unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of toileting unless physical assistance is provided by others 4-6 days per week.

- Never: Applicant is never capable of toileting without physical assistance 7 days per week.

Only when the applicant is incontinent, follow to the next question under Toileting:

QUESTION ON THE PAE: Can applicant perform incontinent care without physical assistance from another person on an ongoing basis?

- Always: Applicant is always capable of performing incontinence care without physical assistance.
- Usually: Applicant is incapable of performing incontinence care and requires physical assistance 1-3 days per week.
- Usually Not: Applicant is incapable of performing incontinence care and requires physical assistance 4-6 days per week.
- Never: Applicant is never capable of performing incontinence care and requires physical assistance 7 days per week.

Mark the type of incontinence, Bowel or Bladder.

Only when the applicant has a catheter or ostomy present, follow to the next question under Toileting:

QUESTION ON THE PAE: Can applicant perform catheter/ ostomy care without physical assistance from another person on an ongoing basis?

- Always: Applicant is always capable of performing catheter/ ostomy care without physical assistance.
- Usually: Applicant is incapable of performing catheter/ ostomy care and requires physical assistance 1-3 days per week.
- Usually Not: Applicant is incapable of performing catheter/ ostomy care and requires physical assistance 4-6 days per week.
- Never: Applicant is never capable of performing catheter/ ostomy care and requires physical assistance 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific type and frequency of toileting assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, nurse's notes, section "G" of MDS

V. Orientation

DEFINITION: Orientation - The applicant is disoriented to person (e.g., fails to remember own name, or recognize immediate family members), place (e.g., does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make good decisions

that prevent risk of harm)

QUESTION ON PAE: Is applicant oriented to person (remembers name; recognizes family), place (does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make decisions that prevent risk of harm)?

HELPFUL HINT: Please note the definition for orientation to person, place and/ or event/situation only; this does NOT include such things as time, or people who are not immediate family. An example may be the applicant does not know who he/she is and/or where he/she is.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always oriented to person, place and event/situation.
- Usually: Applicant is disoriented to person or place or event/situation 1-3 days per week.
- Usually Not: Applicant is disoriented to person or place or event/situation 4-6 days per week.
- Never: Applicant is never oriented to person or place or event/ situation 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific orientation deficits(s), including the frequency of occurrence of such deficit(s), and the impact of such deficit(s) on the Applicant.

*Recommended documentation to support this functional deficit: H&P, plan of Care, Nurse's notes, psych notes, **Mini- Mental Status Exam (MMSE)**, **Saint Louis University Mental Status (SLUMS)***

VI. Communication

DEFINITION: Expressive and Receptive Communication - The Applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including through the use of assistive devices; or the Applicant is incapable of understanding and following very simple instructions and commands without continual intervention

HELPFUL HINT: Communication includes basic information; not complex instructions or complex needs/wants. Possibly ask the person to raise their hands over their head. This would not be to assess movement, but to assess if the person can follow simple instruction. An example may be

that the applicant needs help to let others know that he/she needs to use the toilet.

QUESTION ON PAE: The applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including with the use of assistive devices.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of reliably communicating basic needs and wants.
- Usually: Applicant is incapable of reliably communicating basic needs and wants and requires continual intervention 1-3 days per week.
- Usually Not: Applicant is incapable of reliably communicating basic needs and wants and requires continual intervention 4-6 days per week.
- Never: Applicant is never capable of reliably communicating basic needs and wants and requires continual intervention 7 days per week.

QUESTION ON PAE: The applicant is incapable of understanding and following very simple instructions and commands without continual intervention.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of understanding and following very simple instructions and commands without continual intervention.
- Usually: Applicant is incapable of understanding and following very simple instructions and commands without continual intervention 1-3 days per week.
- Usually Not: Applicant is incapable of understanding and following very simple instructions and commands without continual intervention 4-6 days per week.
- Never: Applicant is never capable of understanding and following very simple instructions and commands without continual intervention 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of communication assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ST notes, Nurse’s notes, psych notes, MMSE, SLUMS

VII. Medications

DEFINITION: Medication Administration - The Applicant is not cognitively or physically capable of self-administering prescribed medications at the prescribed schedule despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to Applicant, reassurance of the correct dose, and the use of assistive devices including a prepared medication box. An occasional lapse in adherence to a medication schedule shall not be sufficient for approval of this deficit; the Applicant must have physical or cognitive impairments which persistently inhibit his or her ability to self-administer medications.

QUESTION ON PAE: Is applicant physically or cognitively able to self-administer medications with limited assistance from others (as described above)?

HELPFUL HINT: This includes physician prescribed PO, IM, RX Otics, Ophthalmics, Topicals, Inhalers, Continuous SQ (subcutaneous) Medications, excluding sliding scale insulin.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of self-administration of prescribed medications.
- Usually: Applicant is incapable of self-administration of prescribed medications without physical intervention 1-3 days per week.
- Usually Not: Applicant is incapable of self-administration of prescribed medications without physical intervention 4-6 days per week.
- Never: Applicant is never capable of self-administration of prescribed medications without physical intervention 7 days per week.

Only when the above question is answered with a **UN** (Usually Not) or **N** (Never), you must list, on the PAE, the medications for which assistance is needed, and provide explanation regarding why applicant is unable to self-administer with limited help from others.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require evidence that such interventions have been tried or would not be successful, and that in the absence of intervention, the Applicant's health would be at serious and imminent risk of harm.

*Recommended documentation to support this functional deficit: H&P, Plan of Care, order/prescription for medications listed as unable to self-administer, **Medication Administration Record (MAR)**, Nurse's notes, **Speech Therapy (ST)** notes*

VIII. Behavior

DEFINITION: Behavior - The Applicant requires persistent staff or caregiver intervention and supervision due to an established and persistent pattern of behavioral problems which are not primarily related to a mental health condition (for which mental health treatment would be the

most appropriate course of treatment) or a substance abuse disorder (for which substance abuse treatment would be the most appropriate course of treatment), and which, absent such continual intervention and supervision, place the Applicant or others at imminent and serious risk of harm. Such behaviors may include physical aggression (including assaultive or self-injurious behavior, destruction of property, resistive or combative to personal and other care, intimidating/threatening, or sexual acting out or exploitation) or inappropriate or unsafe behavior (including disrobing in public, eating non-edible substances, fire setting, unsafe cooking or smoking, wandering, elopement, or getting lost).

QUESTION ON PAE: Does applicant require persistent intervention for an established and persistent pattern of behavioral problems not primarily related to a mental health or substance abuse disorder?

HELPFUL HINT: Notice answers are in reverse from previous options, “Always” referring to the person requires intervention. An example may be the applicant needs someone to intervene daily when he/she attempts to strike their caregiver.

MARK THE ACCURATE ANSWER:

- Always: Applicant always requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 7 days per week.
- Usually: Applicant requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 4-6 days per week.
- Usually Not: Applicant requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 1-3 days per week.
- Never: Applicant never requires persistent intervention due to an established and persistent pattern of behavioral problems.

When the above question is answered with an **A** (Always) or **U** (Usually), you must document and specify, on the PAE, the behavioral problems requiring continual staff or caregiver intervention.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific behaviors and the frequency of such behaviors.

Recommended documentation to support this functional deficit: H&P, Plan of Care, nurse’s notes, psych notes

SKILLED NURSING AND REHABILITATIVE SERVICES

For any applicant who requires one or more of the specified skilled nursing or rehabilitative services and at a frequency (daily for each of the specified skilled services and at least five (5) days per week for each of the specified rehabilitative services) for which level 2 NF reimbursement may be approved by TennCare, the submitter should complete the applicable

portions of the PAE and attach documentation required for the determination of medical eligibility for level 2 or enhanced respiratory care reimbursement (as applicable), regardless of whether the applicant's care will be provided in a NF or in the community.

A Physician's Order will not be required if the skilled or rehabilitative services are being performed by a family member under a specified exemption to the Nurse Practice Act. However, the request must include medical records sufficient to document the need for each skilled or rehabilitative service(s), including the frequency of each service, as would be required for determination of eligibility of a higher level of NF reimbursement. This information will be used for purposes of determining the applicant's total acuity score (regardless of setting), as well as the applicant's cost neutrality cap if enrolled in CHOICES Group 2.

Reimbursement for Level 2 Nursing Facility Services requires specific supporting documentation for approval. This information is available in The PAE Tracking System as you complete this section of the PAE application (attached F). TennCare does not provide reimbursement for rehabilitative services for chronic conditions, exacerbations of chronic conditions, or weakness after hospitalization. Rehabilitative services for maintenance of functional status (e.g., routine range of motion exercises, stand-by assistance during ambulation, or applications of splints/braces) are not considered skilled level services.

While completing your assessment of the applicant preparing to complete the PAE, ensure you compile the appropriate documentation for submission if requesting reimbursement for The Skilled and/ or Rehabilitative services listed below:

- Wound Care for Stage 3 or 4 decubitus
- Other Wound Care (i.e., infected or dehisced wounds)
- Injections, sliding scale insulin
- Injections, other: IV, IM
- Intravenous fluid administration
- Isolation precautions
- *Occupational Therapy by OT or OT assistant
- *Physical Therapy by PT or PT assistant
- Teaching Catheter/Ostomy care
- Teaching self-injection
- Total Parenteral nutrition
- Tube feeding, enteral
- Peritoneal Dialysis
- Patient Controlled Analgesia (PCA) Pump
- New tracheostomy or old tracheostomy requiring suctioning through the tracheostomy multiple times per day at less frequent intervals, i.e., < every 4 hours

ENHANCED RESPIRATORY CARE

NOTE: Reimbursement for NF services at the CV rate can be made *only* to NFs that meet standards of care for delivery of ventilator services, as set forth in TennCare Rules.

In addition to the need for skilled and rehabilitative services counting as part of the total acuity score, NFs use the PAE to serve as authorization for meeting criteria to receive enhanced respiratory care reimbursement.

Reimbursement for Enhanced Respiratory Care rates (and an HCBS Cost Neutrality Cap based on eligibility for such enhanced level of reimbursement) is limited to persons who meet specified medical eligibility criteria below. Approval of Chronic Ventilator (CV) or Tracheal Suctioning (TS) reimbursement (or a Cost Neutrality Cap based on eligibility for such enhanced level of reimbursement) requires specific supporting documentation. The required supporting documentation is specified below for each rate. Documentation requirements may be modified for purposes of a Cost Neutrality Cap Determination, *as noted in italics below*. The specified documentation must be submitted with the PAE and/or Cost Neutrality Determination, as applicable.

While completing your assessment of the applicant preparing to complete the PAE, ensure you compile the appropriate documentation for submission if requesting reimbursement for either chronic ventilator services and/or frequent tracheal suctioning (secretion management).

Chronic Ventilator Services – Provide all the following:

1. Chronic Ventilator reimbursement -the applicant must be ventilator dependent at least 12 hours per day or the use of a Non-Invasive Positive Pressure Ventilation (NIPPV) to delay tracheostomy for progressive neurological disorders.
2. A physician's order for ventilator care (*For Cost Neutrality, submit the physician's order for nursing services.*)
3. A detailed treatment plan developed with input and participation from a pulmonologist or other licensed professional with experience in ventilator care signed by the treating physician or a licensed respiratory care practitioner who will oversee the ventilator care (*For Cost Neutrality, submit the care plan for home-based nursing services.*)

Frequent Tracheal Suctioning (Secretion Management) –In order to be approved for this level of reimbursement the applicant must have a functioning tracheostomy and have a copious volume of secretions (defined as 25-30cc per day). Secretion Management (invasive tracheal suctioning) is one of 2 options; the second is the use of mechanical

airway clearance devices and/or heated high flow molecular humidification via the trach at a minimum of 3 times per day.

1. A physician's order for tracheal suctioning *(For Cost Neutrality, submit the physician's order for nursing services to perform tracheal suctioning.)*
2. A detailed treatment plan signed by the treating physician, licensed registered nurse, or licensed respiratory professional who will oversee the intensive respiratory care *(For Cost Neutrality, submit the care plan for home based nursing services to perform tracheal suctioning.)*
3. *If some of the care is performed by family members or other caregivers, submit detailed documentation of the care provided by family members or other caregivers, in addition to physician's orders and a nursing care plan for services performed by a registered or licensed nurse.*

NOTE: The NF must ensure the availability of necessary equipment, supplies, and appropriately trained and licensed nurses or licensed respiratory care practitioners to perform the specified tasks.

FINALIZING THE FUNCTIONAL ASSESSMENT

Now that you have performed the assessment, you should thoroughly review all the medical documentation you've gathered to support each assessment. This is to ensure documentation is complete and there are no areas of question; all discrepancies should have been remediated during the assessment process. If there are pieces of conflicting information, those areas should be clarified by obtaining additional documentation. Once you have clear and concise information you will assimilate the information in preparation of submitting the PAE in The PAE Tracking System, and if needed, the safety determination request. For every response you mark on each assessment performed, ask yourself the question, "Does my documentation support this response?" If the answer is no, then chances are that TennCare will have the same questions.

6.10 DOCUMENTATION TO SUPPORT THE HCBS GROUP 2 PAE

All PAE submissions are required to have specific supportive documentation reflecting the deficits as identified on the PAE. This documentation will be reviewed by TennCare and compared to the PAE and functional deficits as listed when determining LOC. If supportive documentation is not attached to the PAE according to specifications, LOC may be denied.

The following are required attachments to a HCBS PAE submission;

A recent History and Physical or other supporting medical documentation (completed within 365 days of the PAE Request Date from a MD, DO or advanced practitioner who provided the medical diagnoses which support the applicant’s functional and/or skilled nursing or rehabilitative needs;

- Certification of the level of care assessment by a Qualified Assessor shall be required for all PAEs; and

Complete information regarding PAE Documentation is located in Chapter14.

6.11 HCBS GROUP 2 PAE SUBMISSION

When a HCBS PAE **should** be submitted

- When a NF eligible person requires continuation of the same LOC beyond a PAE expiration date assigned by TennCare
- When a person is applying for CHOICES or PACE
- To determine an individual’s cost neutrality cap for CHOICES Group 2

When a HCBS PAE **must** be submitted

Anytime there is a change in LOC such as:

- When a member enrolled in CHOICES Group 1 or Group 2 no longer meets NF LOC (in place at time of enrollment)
- When a Member enrolled in CHOICES Group 3 no longer meets at risk LOC. When a Member enrolled in CHOICES Group 3 can no longer be safely served in CHOICES Group 3.

When a HCBS PAE is **not required**

- When a Discharge/Transfer/Hospice Form is appropriate.

HCBS GROUP 2 SPECIFIC DOCUMENTATION IN THE PAE TRACKING SYSTEM

Service Requested

Check the box identifying the appropriate service that the applicant requests. If the applicant is choosing to remain in the home and community setting, choose "HCBS".

HCBS Choices

- Check the box identifying the appropriate Target Group of the applicant:
 - If age 65 or older, choose "Age 65+"
 - If age 21 or older, choose "Physically disabled (21+)" and must

list the specific diagnosis or condition relating to the physical disability.

- Check the box identifying the appropriate Cost Neutrality Cap to the applicant's service needs:
 - Level 2: would qualify for skilled services Level 2 SNF care
 - CV (Chronic Ventilator): would qualify for enhanced respiratory care (i.e., for persons who are chronically ventilator dependent).
 - TS (Tracheal Suctioning): would qualify for enhanced respiratory care (i.e., for persons who have a functioning tracheotomy that requires frequent suctioning through the tracheotomy).

- Check the box identifying the appropriate Submission Request Type for the PAE:
 - New CHOICES applicant: a person who is currently not a CHOICES member
 - Change in current LOC: a person who is a current CHOICES member and his/her level of care needs have changed in any manner such that it is not reflected on the current PAE
 - Current CHOICES member, current PAE ending: a person who is a current CHOICES member and his/her PAE is soon to end and the requestor believes CHOICES should continue
 - CN Cap determination: a current Group 2 CHOICES member whose needs have changed and therefore requires a change in the individual cost neutrality cap that is applied

Diagnosis

Enter the full diagnosis that is relevant to the applicant's functional and/or skilled nursing needs. This diagnosis should also be found within the supporting documentation that is attached to the PAE.

Entering the PAE Request Date

This is the date you want the PAE to be effective. As part of the PAE approval process, TennCare will determine the PAE approval effective date and will use what you enter as part of their decision. Please see Chapter 18 to learn more about how TennCare determines a PAE approval effective date.

CERTIFICATION OF THE HCBS GROUP 2 PAE SUBMISSION

The clinical assessor must certify that the level of care information provided on the PAE is accurate. Assessors must also acknowledge that they understand that the information provided is being used to determine Medicaid eligibility and/or reimbursement for long-term services and supports and that any intentional act to provide false information that would potentially result in a person obtaining benefits or coverage that he or she is not entitled to is considered an act of fraud under the State's TennCare program and Title XIX of the Social Security Act. This certification is captured in The PAE Tracking System on the Certification Tab. The PAE Certification Form is signed and dated by the LOC certifier and is included with the PAE application as an attachment in The PAE Tracking System. Sometimes a physician, PA, NP, APN RN, LPN LSW, or TennCare Qualified Assessor allows a PAE to be completed and submitted in The PAE Tracking System by someone else on his/her behalf. In these cases, the physician, PA, NP, APN, RN, LPN, LSW, or TennCare Qualified Assessor continues to assume all responsibility for ensuring that the information as submitted is accurate.

7.0 "AT RISK" LEVEL OF CARE CHOICES GROUP 3

CHOICES is TennCare's program for long-term care services and supports for the elderly (65 years of age and older) and disabled (21 years of age and older). Long-term care includes help doing everyday activities that a person may no longer be able to do for himself as he grows older, or because of a physical disability. CHOICES services include care in a nursing home and certain services to help a person remain at home or in the community. These are called **Home and Community Based Services** or **HCBS**. CHOICES is a managed LTSS program with services offered through TennCare **Managed Care Organizations (MCO)** under contract with TennCare. There are three (3) MCOs: Amerigroup, BlueCare and United HealthCare Community Plan. The MCOs are responsible for coordinating all covered physical, behavioral and LTSS for members who qualify for and are enrolled in CHOICES.

There are three CHOICES Groups discussed in this manual. Participation in CHOICES Group 1 is limited to TennCare members who qualify for and are receiving TennCare-reimbursed **Nursing Facility (NF)** services. Participation in CHOICES Groups 2 and 3 is limited to TennCare members who qualify for and are receiving TennCare-reimbursed HCBS. Group 3 is further limited to

individuals who are Supplemental Security Income from the Social Security Administration (SSI) recipients.

For HCBS applicants who are already Medicaid eligible at the time of CHOICES referral, the MCO perform intake functions, including completion and submission of the PAE to TennCare. The MCO may also assist NF applicants who are already enrolled in Medicaid.

This chapter provides information to facilitate the assessment or data collection, decision making, and PAE submission necessary for CHOICES Group 3. These individuals are not eligible for NF care but are “At Risk” of NF placement and are requesting HCBS in CHOICES to receive Level of Care criteria and are TennCare-reimbursed Home Community Based Services.

7.1 MEDICAL NECESSITY OF CARE FOR “At Risk” CHOICES GROUP 3

Group 3 individuals are not eligible for NF care but are “at risk” of NF placement.

In order to meet At Risk LOC requirements TennCare must determine that an applicant meets both of the following criteria:

1. Medical Necessity of Care and
2. Need for inpatient Nursing Care by demonstration of having at least one significant functional deficit (and need assistance daily or at least 4 days per week) for the significant functional deficit; ADL or ADL Related function as indicated and approved on the PAE application. (concept from chapter 10 pg. 39)

The person does not necessarily require daily *inpatient nursing care*, but must require ongoing supervision and/or assistance with activities of daily living in the home or community setting. While services do not have to be required on a *daily* basis, the need for assistance must be ongoing such that the person would otherwise not be able to safely live in the community and would be at risk of placement in a NF in order to be eligible to receive HCBS Group 3. Thus, the need for inpatient care as it relates to persons not eligible to receive care in a NF, but requesting HCBS is as follows:

- The member has a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting.
- In the absence of such HCBS, the person would not be able to live safely in the community and would be at risk of NF placement.

- The individual must be unable to self-perform needed assistance and must have a significant deficit (needing assistance daily or at least four days per week) in an activity of daily living or related function as captured on the PAE application.

These criteria are satisfied in part by the diagnosis listed on the PAE in the PAE Tracking System and must be supported by medical evidence. The PAE nurse also reviews the functional assessment and supporting medical documentation to determine if at least one significant deficit exists. A significant deficit is a deficit in an ADL or related function as listed on the PAE application that requires assistance daily or at least 4 times weekly. An acuity score is not used to determine if a person meets At Risk LOC.

TennCare makes this determination using all the information that is provided with the PAE application.

7.2 LOC ACUITY SCALE

An acuity score is not used to determine if a person meets HCBS Group 3 “AT Risk” LOC.

Instead, these criteria are satisfied in part by the diagnosis listed on the PAE in the PAE Tracking System and supported by medical evidence submitted. The PAE nurse also reviews the functional assessment and supporting medical documentation to determine if at least one significant deficit exists. A ***significant deficit*** is a deficit in an ADL or related function as listed on the PAE application that requires assistance daily or at least 4 times weekly.

The functional needs as captured on the PAE include the applicant’s need for assistance with the following Activities of Daily Living (ADLs):

- Transfer;
- Mobility;
- Eating; and
- Toileting;

And deficits in the following ADL-related functions:

- Communication (expressive and receptive);
- Orientation (to person, place, or event/situation);
- Behaviors; and
- Self-administration of medications

The TennCare NF LOC Acuity Scale is attached. (Attachment A)

7.3 QUALIFICATIONS FOR ENROLLMENT IN “AT Risk” GROUP 3

1. An applicant must have an approved unexpired PAE for at risk LOC;
2. An applicant must be approved financially for TennCare reimbursement of LTSS as an SSI recipient (for interim (until June 30th, 2015) CHOICES Group 3, in an institutional category);
3. An applicant must be in one of the target populations (age 65 and older OR age 21 and older with a physical disability as defined by TennCare);
4. An applicant must be able and willing to begin receiving HCBS: and
5. TennCare must have received a determination by the MCO or AAAD that the individual’s needs can be safely and appropriately met in the community, and at a cost that does not exceed the Expenditure Cap.

QUALIFICATIONS FOR ENTROLLMENT IN “AT RISK” GROUP 3 THROUGH SAFETY

Once a person is determined not to have a score of at least 9 on the TennCare Acuity Scale (attachment A), the PAE nurse determines by reviewing all the information submitted with the PAE if the person meets “At Risk” LOC. If a person does not meet NF LOC requirements but does meet “At Risk” LOC requirements, TennCare must determine if enrollment criteria for CHOICES Group 3 is met. This decision includes a determination that:

- a) The applicant is in the defined target population for CHOICES HCBS (age 65 or older or age 21 or older with physical disabilities);
- b) The applicant’s needs can be safely and appropriately met in the community with the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3, including CHOICES HCBS up to the expenditure cap of \$15,000, non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers.

TennCare makes this safety determination only when a complete safety determination request is received. TennCare makes this determination only when a complete safety determination request is received. Individuals who meet At Risk LOC requirements who cannot be safely served if enrolled in CHOICES Group 3 will be granted NF LOC approval and as long as all other enrollment and eligibility requirements are met, will be approved for TennCare reimbursed NF services through CHOICES Group 1 or for more comprehensive HCBS through CHOICES Group 2 or PACE.

Note:

An applicant who could be safely served in CHOICES Group 3 except that he does not meet Medicaid categorical and financial eligibility criteria for CHOICES Group 3 (i.e. is not an SSI recipient) shall not be eligible for CHOICES Group 1 or Group 2 as a result of a Safety Determination.

7.4 CHOICES “AT RISK” GROUP 3 TRANSITIONS

Transition from CHOICES Group 1 or Group 2 to Group 3:

TennCare or the MCO shall, subject to eligibility and enrollment criteria, initiate a transition from Group 1 or 2 to Group 3 when a member who was enrolled in CHOICES Group 1 or Group 2 on or after July 1, 2012 no longer meets NF LOC but meets At Risk LOC. A member that has already been discharged from the NF shall not be transitioned from CHOICES Group 1 to CHOICES Group 3. Once a Member has discharged from the NF, he has voluntarily disenrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 3. In these instances, a new HCBS PAE shall be required for enrollment into CHOICES Group 3.

When a member transitions from CHOICES Group 1 to Group 3 TennCare Member Services must recalculate the Member’s Patient Liability. The member must also qualify as an SSI recipient at the time of transition.

Transition from CHOICES Group 3 to Group 1 or Group 2:

TennCare or the MCO shall initiate a transition from Group 3 to Group 1 or Group 2, as appropriate, when the member meets NF LOC and satisfies all requirements for enrollment into the requested Group. When a member transitions from Group 3 to Group 1, TennCare Member Services must recalculate the member’s Patient Liability.

Transitions based on safety:

For existing CHOICES members, assessments are completed by the MCO annually and upon a change of the member’s status/ condition. If at any time the MCO determines that the

member's needs can no longer be safely met in the current care setting, the MCO may initiate and submit to TennCare a request for a safety determination as described in TennCare Rule. This determination must be made considering all covered services and supports available within either the individual's cost neutrality cap for Group 2 members, or expenditure cap for Group 3 members. TennCare must approve the MCO's determination to transition due to safety and/or cost neutrality. If a member does not wish to transition to another CHOICES Group so that his needs can be safely met, the MCO may initiate CHOICES disenrollment proceedings.

7.5 CHOICES "AT RISK" GROUP 3 PAE ASSESSMENTS

Now that you are familiar with CHOICES and have an understanding about eligibility and enrollment criteria, we will introduce the process for completing a PAE application so that TennCare may determine level or care, or medical eligibility, for CHOICES and PACE. Remember, for an applicant to qualify for CHOICES Group 1, 2 or PACE, the NF LOC must be approved. To qualify for CHOICES Group 3, "At Risk" LOC must be approved. Also, as described previously there are other enrollment and eligibility requirements that must be satisfied prior to an applicant's enrollment into CHOICES Group 3. This section will walk you through preliminary assessment information necessary to conduct assessments for CHOICES HCBS Group 3.

WHO CAN COMPLETE A HCBS ASSESSMENT?

Assessors are clinically trained staff (employed by a PACE Organization, MCO or AAAD) who have completed an in person TennCare training about LTSS Programs and the HCBS PAE application process. The assessor must be a Physician (MD or DO), Physician Assistant (PA), Nurse Practitioner (NP), Advanced Practice Nurse (APN), Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Social Worker (LSW). HCBS assessors must be TennCare Qualified Assessors.

Additionally, TennCare Qualified Assessors for HCBS must, in addition to meeting the qualifications above, take and pass a test measuring their understanding of HCBS requirements and renew their qualified Assessor status annually. Qualified Assessors are assigned a unique Qualified Assessor Code. This code must be documented on the PAE with the Assessor Certification signature. TennCare will only accept HCBS PAE assessments performed by individuals who have been deemed a HCBS Qualified Assessor (regardless of TPAES submitter). HCBS Qualified Assessor trainings are offered by TennCare on a regular basis. Qualified Assessors must complete an online test to renew HCBS Qualified Assessor status annually.

HCBS PAE CERTIFICATION

The clinical assessor must certify that the level of care information provided on the PAE is accurate. Assessors must also acknowledge that they understand that the information provided is being used to determine Medicaid eligibility and/or reimbursement for long-term services and supports and that any intentional act to provide false information that would potentially result in a person obtaining benefits or coverage that he or she is not entitled to is considered an act of fraud under the State's TennCare program and Title XIX of the Social Security Act. This certification is captured in The PAE Tracking System on the Certification Tab. The PAE Certification Form is signed and dated by the LOC certifier and is included with the PAE application as an attachment in The PAE Tracking System. Sometimes a physician, PA, NP, APN RN, LPN LSW, or TennCare Qualified Assessor allows a PAE to be completed and submitted in The PAE Tracking System by someone else on his/her behalf. In these cases, the physician, PA, NP, APN, RN, LPN, LSW, or TennCare Qualified Assessor continues to assume all responsibility for ensuring that the information as submitted is accurate.

INTERVIEWING PROCESS FOR AN HCBS PAE

TennCare has provided applicant and collateral interview tools to assist with the PAE application process to help paint a clear picture of the applicant and assistance they require. These tools are not a requirement, but it is recommended they be utilized along with supporting medical documentation.

The preferred source of information is the client. If there is another person in the room when the client is being interviewed, questions should continue to be directed to the client. If others who are present try to answer questions for the client, they should be asked not to assist with responses or provide reminders or hints. They will be given the opportunity to complete their own interview.

Other sources of information, such as the primary caregiver, family members, other helpers, friends, neighbors and/or provider staff should also be used. For the completion of some sections of the assessment, the assessor may need to interview other professional staff such as physicians, nurses, or social workers. Also, it may be necessary to obtain a translator or some other spokesperson for the individual. It will be important to know ahead of time if possible, to prepare for the interview beforehand.

Although it is recommended, it is not necessary to seek information in the exact order in which appears on the form. The form is designed with a logical flow and is intended to appear reasonable to the applicant. However, because applicants will present information in their own way, it is not necessary to ask questions which have already been answered in the course of the interview, just record the answer already given.

ASKING QUESTIONS FOR AN HCBS PAE

A good clinical interviewer is always on the lookout for both themes and discrepancies. Themes help you note and describe patterns across time. These patterns may be critical to understanding both how to leverage the person's strengths and to understand how best to support the person to prevent patterns of difficulties. An assessor should never lead the respondents toward a particular answer but is encouraged to ask for descriptions and clarifications that will help the respondent or the assessor to resolve discrepancies or inconsistencies in the information being received. Being alert for discrepancies to conflicting reports ensures that the assessor gets clarification to clarify promptly when information just doesn't add up.

It is important that the assessor avoids using "buzz words", generalizations, or reporting opinions instead of descriptions and observations. Provide objective, extensive and clear descriptions of the person's medical, functional and behavioral status. When describing behavioral symptoms, remember that the same behavioral symptoms can present very differently for each person. One person's experience of "agitated" can involve violent or aggressive behaviors, while another person's experience may involve irritability, lack of sleep and extreme restlessness. It is important to describe in detail what behaviors, support needs, etc. look like for that person. Tell the story of their current presentation.

Ensure the assessment form provides a clear, detailed and consistent picture of the individual's functional status.

The best guidance for a great clinical interview is to collect individualized, detailed information from a variety of sources to ensure that the individual's unique needs and characteristics are reflected. The quality of this process is directly correlated to the quality of the clinical interview.

7.6 FUNCTIONAL ASSESSMENT

Now that you understand who can perform assessments it's important for all submitters to understand how to complete the functional assessment on the PAE. Remember, there are two components of level of care (LOC) eligibility:

- Medical necessity of care; and
- Need for inpatient care

Both components apply to Nursing Facility LOC and At Risk LOC. The functional assessment and supporting medical evidence included with the PAE application is used to determine if the Need for Inpatient Care requirement is satisfied when determining LOC.

First, we'll walk through how to measure levels of functional deficit on the PAE. Next, we'll cover each functional area and the applicant's need for assistance. Then we'll explain how the need for skilled and/or rehabilitative services is documented on the PAE.

Measuring Functional Deficits

On the PAE, there are 4 possible responses to each question. *Except* for behavior, **"Always"** means that the applicant is **always independent** with that ADL or related activity. **"Usually"** means that the person is **usually independent** (requiring assistance fewer than 4 days per week). **"Usually not"** means that the applicant is usually not independent (requiring assistance 4 or more days per week). **"Never"** means that the applicant is **never independent** with that ADL or related activity.

With respect to behavior, the responses are reversed. **"Always"** means that the applicant always requires intervention for behaviors. **"Usually"** means that the applicant requires intervention for behaviors 4 or more days per week. **"Usually not"** means that the applicant requires intervention for behaviors, but fewer than 4 days per week. **"Never"** means that the applicant does not have behaviors that require intervention.

TennCare has assigned a weighted value to each of the possible responses to each question on the PAE, based on the amount of assistance that would be required for a person with that type and level of ADL or related deficit. The TennCare NF LOC Acuity Scale (Attachment A) provides the weight given to each functional measure and response. Each response must be supported by the medical evidence submitted with the PAE for the assigned acuity score to be approved by TennCare.

ADLs and ADL-related functions

When providing responses to each functional measure as indicated on the functional assessment, you should consider the act of physical assistance being "hands on" care. You should also consider a person's functionality in a 24 hour/7 days a week window of need. Some patients may appear, during your presence, to be functioning well in an area that they may not function well at in different times/days. For example, someone may be only incontinent at night, but continent the rest of the day. When these types of situations exist, it is important to clearly explain it on the PAE as a note or comments in The PAE Tracking System.

I. Transfer

DEFINITION: Transfer - The applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis. **QUESTION ON PAE:** Can applicant transfer to and from bed, chair or toilet without physical help from others?

HELPFUL HINT: This is moving the body from one place to another without ambulating (which is covered under the Mobility section). It is important to note the definition applies to bed, chair, or toilet only. An example may be that the applicant needs someone to hold onto him to successfully get up/down from the bed and on/off the toilet.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of transfer to and from bed, chair, or toilet without physical assistance from others.
- Usually: Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of transfer to and from bed, chair, or toilet without physical assistance 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit requires documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of transfer assistance required.

*Recommended documentation to support this functional deficit: medical **H**istory and **P**hysical (**H&P**), ADL flow sheets, PT notes, nurse's notes, section "G" of **Minimum Data Set (MDS)***

II. Mobility

DEFINITION: Mobility - The applicant requires physical assistance from another person for mobility on an ongoing basis. Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair (manual or electric) if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

QUESTION ON PAE: Can applicant walk without physical help from others?

HELPFUL HINT: This is the act of moving from one place to another. In other words, if someone is able to get from one place to another using their manual or power wheelchair, this would be considered "mobile". An example may be that the applicant needs someone to hold on to him when he is ambulating with his cane.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of walking without physical assistance.
- Usually: Applicant is incapable of walking unless physical assistance is provided by others 1-3 days per week.

- Usually Not: Applicant is incapable walking unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of walking without physical assistance 7 days per week.

Only when the above question is answered with a **UN** (Usually Not) or **N** (Never), follow to the next question under Mobility:

QUESTION ON PAE: If walking is not feasible (answer to mobility question above is UN or N), is Applicant capable of using a wheelchair, either manual or electric?

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of mobility without physical assistance.
- Usually: Applicant is incapable of wheelchair mobility unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of wheelchair mobility unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of wheelchair mobility without physical assistance 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of mobility assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, PT notes, nurse's notes, section "G" of MDS

III. Eating

DEFINITION: Eating - The Applicant requires physical assistance with gastrostomy tube feedings or physical assistance or constant one-on-one observation and verbal assistance (reminding, encouraging to consume prepared food and drink or self-administer tube feedings, as applicable) or must be fed part or all of each meal. Food preparation, tray set-up, assistance in cutting up foods, and general supervision of multiple residents shall not be considered to meet this requirement.

QUESTION ON PAE: Can applicant eat (or physically self-administer tube feeding as applicable) without help from others?

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of eating without help from others.
- Usually: Applicant is incapable of eating without help from others 1-3 days per week.

- Usually Not: Applicant is incapable of eating without help from others 4-6 days per week.
- Never: Applicant is never capable of eating without help from others 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation which supports the need for such intervention, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task. For PAEs submitted by the AAAD (or entity other than an MCO, NF, or PACE Organization), an eating or feeding plan specifying the type, frequency and duration of supports required by the Applicant for feeding, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task shall be required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, OT/ST notes, nurse's notes, swallow study, section "G" of MDS

IV. Toileting

DEFINITION: Toileting - The applicant requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or catheter care on an ongoing basis

QUESTION ON THE PAE: Can applicant toilet without physical assistance from others?

HELPFUL HINT: Includes the act of toileting, adjusting clothing and/or being able to properly clean oneself. This does NOT include the act of getting on/off the toilet as this is accounted for in the Transfer question. Incontinence is scored separately, for example someone may usually be able to toilet but is incontinent and can never clean themselves. Some people can have an indwelling catheter and care for it themselves, do not assume the presence of one means the person is never able to self-care. An example may be the applicant needs someone to clean him/herself and help him/her pull up their pants and buckle their belt after toileting.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of toileting without physical assistance.
- Usually: Applicant is incapable of toileting unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of toileting unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of toileting without physical assistance 7 days per week.

Only when the applicant is incontinent, follow to the next question under Toileting:

QUESTION ON THE PAE: Can applicant perform incontinent care without physical assistance from another person on an ongoing basis?

- Always: Applicant is always capable of performing incontinence care without physical assistance.
- Usually: Applicant is incapable of performing incontinence care and requires physical assistance 1-3 days per week.
- Usually Not: Applicant is incapable of performing incontinence care and requires physical assistance 4-6 days per week.
- Never: Applicant is never capable of performing incontinence care and requires physical assistance 7days per week.

Mark the type of incontinence, Bowel or Bladder.

Only when the applicant has a catheter or ostomy present, follow to the next question under Toileting:

QUESTION ON THE PAE: Can applicant perform catheter/ ostomy care without physical assistance from another person on an ongoing basis?

- Always: Applicant is always capable of performing catheter/ ostomy care without physical assistance.
- Usually: Applicant is incapable of performing catheter/ ostomy care and requires physical assistance 1-3 days per week.
- Usually Not: Applicant is incapable of performing catheter/ ostomy care and requires physical assistance 4-6 days per week.
- Never: Applicant is never capable of performing catheter/ ostomy care and requires physical assistance 7days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific type and frequency of toileting assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, nurse’s notes, section “G” of MDS

V. Orientation

DEFINITION: Orientation - The applicant is disoriented to person (e.g., fails to remember own name, or recognize immediate family members), place (e.g., does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make good decisions that prevent risk of harm)

QUESTION ON PAE: Is applicant oriented to person (remembers name; recognizes family), place (does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make decisions that prevent risk of harm)?

HELPFUL HINT: Please note the definition for orientation to person, place and/ or event/situation only; this does NOT include such things as time, or people who are not immediate family. An example may be the applicant does not know who he/she is and/or where he/she is.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always oriented to person, place and event/situation.
- Usually: Applicant is disoriented to person or place or event/situation 1-3 days per week.
- Usually Not: Applicant is disoriented to person or place or event/situation 4-6 days per week.
- Never: Applicant is never oriented to person or place or event/ situation 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific orientation deficits(s), including the frequency of occurrence of such deficit(s), and the impact of such deficit(s) on the Applicant.

*Recommended documentation to support this functional deficit: H&P, plan of Care, Nurse's notes, psych notes, **Mini- Mental Status Exam (MMSE)**, **Saint Louis University Mental Status (SLUMS)***

VI. Communication

DEFINITION: Expressive and Receptive Communication - The Applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including through the use of assistive devices; or the Applicant is incapable of understanding and following very simple instructions and commands without continual intervention

HELPFUL HINT: Communication includes basic information; not complex instructions or complex needs/wants. Possibly ask the person to raise their hands over their head. This would not be to assess movement, but to assess if the person can follow simple instruction. An example may be that the applicant needs help to let others know that he/she needs to use the toilet.

QUESTION ON PAE: The applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including with the use of assistive devices.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of reliably communicating basic needs and wants.
- Usually: Applicant is incapable of reliably communicating basic needs and wants and requires continual intervention 1-3 days per week.
- Usually Not: Applicant is incapable of reliably communicating basic needs and wants and requires continual intervention 4-6 days per week.
- Never: Applicant is never capable of reliably communicating basic needs and wants and requires continual intervention 7 days per week.

QUESTION ON PAE: The applicant is incapable of understanding and following very simple instructions and commands without continual intervention.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of understanding and following very simple instructions and commands without continual intervention.
- Usually: Applicant is incapable of understanding and following very simple instructions and commands without continual intervention 1-3 days per week.
- Usually Not: Applicant is incapable of understanding and following very simple instructions and commands without continual intervention 4-6 days per week.
- Never: Applicant is never capable of understanding and following very simple instructions and commands without continual intervention 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of communication assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ST notes, Nurse’s notes, psych notes, MMSE, SLUMS

VII. Medications

DEFINITION: Medication Administration - The Applicant is not cognitively or physically capable of self-administering prescribed medications at the prescribed schedule despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to,

reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to Applicant, reassurance of the correct dose, and the use of assistive devices including a prepared medication box. An occasional lapse in adherence to a medication schedule shall not be sufficient for approval of this deficit; the Applicant must have physical or cognitive impairments which persistently inhibit his or her ability to self-administer medications.

QUESTION ON PAE: Is applicant physically or cognitively able to self-administer medications with limited assistance from others (as described above)?

HELPFUL HINT: This includes physician prescribed PO, IM, RX Otics, Ophthalmics, Topicals, Inhalers, Continuous SQ (subcutaneous) Medications, excluding sliding scale insulin.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of self-administration of prescribed medications.
- Usually: Applicant is incapable of self-administration of prescribed medications without physical intervention 1-3 days per week.
- Usually Not: Applicant is incapable of self-administration of prescribed medications without physical intervention 4-6 days per week.
- Never: Applicant is never capable of self-administration of prescribed medications without physical intervention 7 days per week.

Only when the above question is answered with a **UN** (Usually Not) or **N** (Never), you must list, on the PAE, the medications for which assistance is needed, and provide explanation regarding why applicant is unable to self-administer with limited help from others.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require evidence that such interventions have been tried or would not be successful, and that in the absence of intervention, the Applicant's health would be at serious and imminent risk of harm.

*Recommended documentation to support this functional deficit: H&P, Plan of Care, order/prescription for medications listed as unable to self-administer, **Medication Administration Record (MAR)**, Nurse's notes, **Speech Therapy (ST)** notes*

VIII. Behavior

DEFINITION: Behavior - The Applicant requires persistent staff or caregiver intervention and supervision due to an established and persistent pattern of behavioral problems which are not primarily related to a mental health condition (for which mental health treatment would be the most appropriate course of treatment) or a substance abuse disorder (for which substance abuse treatment would be the most appropriate course of treatment), and which, absent such continual intervention and supervision, place the Applicant or others at imminent and serious

risk of harm. Such behaviors may include physical aggression (including assaultive or self-injurious behavior, destruction of property, resistive or combative to personal and other care, intimidating/threatening, or sexual acting out or exploitation) or inappropriate or unsafe behavior (including disrobing in public, eating non-edible substances, fire setting, unsafe cooking or smoking, wandering, elopement, or getting lost).

QUESTION ON PAE: Does applicant require persistent intervention for an established and persistent pattern of behavioral problems not primarily related to a mental health or substance abuse disorder?

HELPFUL HINT: Notice answers are in reverse from previous options, “Always” referring to the person requires intervention. An example may be the applicant needs someone to intervene daily when he/she attempts to strike their caregiver.

MARK THE ACCURATE ANSWER:

- Always: Applicant always requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 7 days per week.
- Usually: Applicant requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 4-6 days per week.
- Usually Not: Applicant requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 1-3 days per week.
- Never: Applicant never requires persistent intervention due to an established and persistent pattern of behavioral problems.

When the above question is answered with an **A** (Always) or **U** (Usually), you must document and specify, on the PAE, the behavioral problems requiring continual staff or caregiver intervention.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific behaviors and the frequency of such behaviors.

Recommended documentation to support this functional deficit: H&P, Plan of Care, nurse’s notes, psych notes

FINALIZING THE FUNCTIONAL ASSESSMENT

Now that you have performed the assessment, you should thoroughly review all the medical documentation you’ve gathered to support each assessment. This is to ensure documentation is complete and there are no areas of question; all discrepancies should have been remediated during the assessment process. If there are pieces of conflicting information, those areas should be clarified by obtaining additional documentation. Once you have clear and concise information you will assimilate the information in preparation of submitting the PAE in The PAE Tracking System, and if needed, the safety determination request. For every response you mark

on each assessment performed, ask yourself the question, “Does my documentation support this response?” If the answer is no, then chances are that TennCare will have the same questions.

7.7 SAFETY DETERMINATION

The need for inpatient care requirement of NF LOC may be satisfied with either a total acuity score of 9 or a determination that a person who meets At Risk LOC does not qualify for enrollment into CHOICES Group 3. A submitting entity may demonstrate on the PAE application that a person does not qualify for enrollment into CHOICES Group 3 because they cannot be safely served using the full array of benefits and services available. A safety determination request can also be made upon the request of the applicant or the applicant’s representative. In these cases, the submitting entity indicates the request is made by the applicant and/or family member.

A safety determination is defined in TennCare Rule as a TennCare decision regarding whether an applicant would qualify to enroll in CHOICES Group 3 or if there is sufficient evidence to demonstrate that the necessary intervention and supervision needed by the applicant cannot be safely provided within the array of services and supports that would be available if the Applicant was enrolled in Choices Group 3, including CHOICES HCBS up to the Expenditure Cap of \$15,000, non-Choices HCBS available through TennCare (e.g., home health), cost-effective alternative services (as applicable), services available through Medicare, private insurance or other funding sources, and natural supports provided by family members and other caregivers who are willing and able to provide such care. For detailed information about services available in Group 3 up to the \$15,000 Expenditure Cap and other available TennCare services, please see list of Group 3 Services (attachment G). It is also important to remember that the MCO may authorize **Cost Effective Alternatives (CEA)** above the expenditure cap. More information about a CEA can be found on the TennCare website.

DECIDING IF A TENNCARE SAFETY DETERMINATION SHOULD BE REQUESTED

A Safety Determination by TennCare regarding whether an applicant would qualify for enrollment into CHOICES Group 3 can be made upon request of the applicant, the applicant’s representative, or the entity submitting the PAE including the AAAD, MCO, NF, or PACE Organization if at least one of the following criteria are met:

1. The applicant has an approved total acuity score of at least five (5) and safety concerns impacting the applicant’s ability to be safely served in CHOICES Group 3 exist;

2. The applicant has an approved individual acuity score of at least three (3) for the mobility or transfer measures and the absence of frequent intermittent assistance for mobility or transfer needs would result in imminent and serious risk to the applicant's health and safety; (documentation of the mobility/ transfer deficits and the lack of availability of assistance for mobility/transfer needs is required);
3. The applicant has an approved individual acuity score of at least two (2) for the toileting measure, and the absence of frequent intermittent assistance for toileting needs would result in imminent and serious risk to the applicant's health and safety (documentation of the toileting deficits and the lack of availability of assistance for toileting needs is required);
4. The applicant has an approved individual acuity score of at least three (3) for the Orientation measure and the absence of frequent intermittent or continuous intervention and supervision would result in imminent and serious risk of harm to the applicant and/or others (documentation of the impact of such deficits on the applicant's safety, including information or examples that would support and describe the imminence and seriousness of risk is required);
5. The applicant has an approved individual acuity score of at least two (2) for the Behavior measure and the absence of intervention and supervision for behaviors at the frequency specified in the PAE would result in imminent and serious risk of harm to the applicant and/or others (in addition to information submitted with the PAE, information or examples that would support and describe the imminence and seriousness of risk resulting from the behaviors is required);
6. The applicant has experienced a significant change in physical or behavioral health or functional needs, or the applicant's caregiver has experienced a significant change in physical or behavioral health or functional needs which impacts the availability of needed assistance for the applicant;
7. The applicant has a pattern of recent falls resulting in injury or with significant potential for injury or a recent fall under circumstances indicating a significant potential risk for further falls (documentation of the falls is required; Fall Form may be utilized);
8. The applicant has an established pattern of recent emergent hospital admissions or emergency department utilization for emergent conditions or a recent hospital or NF admission or episode of treatment in a hospital emergency department under circumstances sufficient to indicate that the person may not be capable of being safely maintained in the community (not every hospital or NF admission or ER episode will be sufficient support);
9. The applicant's behaviors or a pattern of self-neglect has created a risk to personal health, safety and/or welfare that has prompted intervention by law enforcement or Adult Protective Services. A report of APS or law enforcement involvement shall be

- sufficient by itself to require the conduct of a Safety Determination (but not necessarily the approval of a Safety Determination);
10. The Applicant has recently been discharged from a community-based residential alternative setting (or such discharge is pending) because the applicant's needs can no longer be safely met in that setting;
 11. The applicant has diagnosed complex acute or chronic medical conditions which require frequent, ongoing skilled and/or rehabilitative interventions and treatment by licensed professional staff;
 12. The applicant requires post-acute inpatient treatment for a specified period of time to allow for stabilization, rehabilitation or intensive teaching in order to facilitate a safe transition into the community;
 13. The applicant's MCO has determined, upon enrollment into Group 3 based on a PAE submitted by another entity, that the Applicant's needs cannot be safely met within the array of services and supports available if enrolled in Group 3, such that a higher level of care is needed.
 14. None of the criteria above have been met, but other safety concerns which impact the applicant being safely served in CHOICES Group 3 exist (a detailed description of the safety concern and sufficient evidence showing the necessary intervention and supervision needed by the applicant must be included); OR
 15. The applicant is a current CHOICES Group 1 or Group 2 member or PACE member enrolled on or after July 1, 2012 and has been determined upon review to no longer meet NF LOC based on a total acuity score of 9 or above but because of specific safety concerns, still requires the level of care currently being provided (a justification and associated documentation must be represented in at least one of the areas listed above).

PAEs may be submitted by more than one entity on behalf of an applicant. If Entity #1 (e.g., the MCO) believes that an applicant's needs can be safely met if enrolled in Group 3 and a Safety Determination is not needed for the applicant, but Entity #2 (e.g., the NF) believes that a Safety Determination is appropriate, then Entity #2 (e.g., the NF) may also submit a PAE on behalf of the applicant, along with a completed Safety Determination request, to the Bureau for review.

If the applicant meets one of the requirements above and the submitting entity (MCO, AAAD, NF, PACE Organization) or the applicant/representative has requested a safety review, the PAE assessor must complete all actions necessary to successfully submit the safety determination request.

REQUESTING A SAFETY DETERMINATION

TennCare has made available a Safety Determination Request Form (attachment H) which will guide the PAE assessor through the safety determination request process. The Safety Determination Request Form is also required to be completed and submitted with the PAE and safety determination request in The PAE Tracking System. Additional documentation required to support a Safety Determination request shall include all the following:

1. A completed PAE that includes:
 - a. A detailed explanation of each ADL or related deficiency (as required by TennCare);
 - b. A completed Safety Determination Request Form and Medical evidence sufficient to support the functional and related deficits identified on the PAE and the health and safety risks identified on the safety determination request form. Documentation to support the safety justification may consist of, but is not limited to, narrative descriptions or explanations from submitter, caregivers, or family members; hospital notes, therapy notes, MD visits, ADL flow sheets, encounter notes from nurses, therapists, or physicians; and any other documents which would demonstrate the safety concern(s) for the applicant.
2. A comprehensive needs assessment which shall include all of the following:
 - a. An assessment of the applicant's physical, behavioral, and psychosocial needs not reflected in the PAE, including the specific tasks and functions for which assistance is needed by the applicant, the frequency with which such tasks must be performed, and the applicant's need for safety monitoring and supervision;
 - b. The applicant's living arrangements and the services and supports the applicant has received for the six (6) months prior to submission of the safety determination request, including unpaid care provided by family members and other caregivers, paid services and supports the applicant has been receiving regardless of payer (e.g., non-CHOICES HCBS available through TennCare such as home health and services available through Medicare, private insurance or other funding sources); and any anticipated change in the availability of such care or services from the current caregiver or payer; and
 - c. Detailed explanation regarding any recent significant event(s) or circumstances that have impacted the applicant's need for services and supports, including how such event(s) or circumstances impact the applicant's ability to be safely supported within the array of covered services and supports that would be available if the applicant were enrolled in CHOICES Group 3;
2. A person-centered plan of care developed by the MCO Care Coordinator, NF, or PACE Organization (i.e., the entity submitting the Safety Determination request) which specifies the tasks and functions for which assistance is needed by the applicant, the

frequency with which such tasks must be performed, the applicant's need for safety monitoring and supervision; and the amount (e.g., minutes, hours, etc.) of paid assistance that would be necessary to provide such assistance; and that would be provided by such entity upon approval of the safety determination. (A person-centered plan of care is not required for a safety determination submitted by the AAAD.) In the case of a Safety Determination request submitted by an MCO or AAAD for a NF resident, the plan of care shall be developed in collaboration with the NF, as appropriate; and

3. An explanation regarding why an array of covered services and supports, including CHOICES HCBS up to the Expenditure Cap of \$15,000 and non- CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the applicant's needs in the community.

As explained in Chapter 8, the need for inpatient care requirement of NF LOC may be satisfied with either a total acuity score of 9 or a determination that a person who meets At Risk LOC does not qualify for enrollment into CHOICES Group 3. A submitting entity may demonstrate on the PAE application that a person does not qualify for enrollment into CHOICES Group 3 because they cannot be safely served using the full array of benefits and services available. A safety determination request can also be made upon the request of the applicant or the applicant's representative. In these cases, the submitting entity indicates the request is made by the applicant and/or family member.

A safety determination is defined in TennCare Rule as a TennCare decision regarding whether an applicant would qualify to enroll in CHOICES Group 3 or if there is sufficient evidence to demonstrate that the necessary intervention and supervision needed by the applicant cannot be safely provided within the array of services and supports that would be available if the Applicant was enrolled in Choices Group 3, including CHOICES HCBS up to the Expenditure Cap of \$15,000, non-Choices HCBS available through TennCare (e.g., home health), cost-effective alternative services (as applicable), services available through Medicare, private insurance or other funding sources, and natural supports provided by family members and other caregivers who are willing and able to provide such care. For detailed information about services available in Group 3 up to the \$15,000 Expenditure Cap and other available TennCare services, please see list of Group 3 Services (attachment G). It is also important to remember that the MCO may authorize **Cost Effective Alternatives (CEA)** above the expenditure cap. More information about a CEA can be found on the TennCare website.

7.8 DOCUMENTATION TO SUPPORT THE “AT Risk” Group 3 PAE

All PAE submissions are required to have specific supportive documentation reflecting the deficits as identified on the PAE. This documentation will be reviewed by TennCare and compared to the PAE and functional deficits as listed when determining LOC. If supportive documentation is not attached to the PAE according to specifications, LOC may be denied.

The following are required attachments to a HCBS PAE submission;

- A recent History and Physical (completed within 365 days of the PAE Request Date or date of Physician Certification, whichever is earlier) AND/OR other recent medical records from a MD, DO or advanced practitioner who provided the medical diagnoses which support the applicant’s functional and/or skilled nursing or rehabilitative needs;
- Certification of the level of care assessment by a Qualified Assessor shall be required for all PAEs; and
- HCBS documentation tools (applicant and collateral tools) are optional to be completed and submitted with all HCBS PAEs (attachments D&E).

“AT RISK” GROUP 3 SPECIFIC DOCUMENTATION IN THE PAE TRACKING SYSTEM

Service Requested

Check the box identifying the appropriate service that the applicant requests. If the applicant is choosing to remain in the home and community setting, choose "HCBS".

HCBS Choices

- Check the box identifying the appropriate Target Group of the applicant:
 - If age 65 or older, choose "Age 65+"
 - If age 21 or older, choose "Physically disabled (21+)" and list the specific diagnosis or condition relating to the physical disability.
- Check the box identifying the appropriate Submission Request Type for the PAE:
 - New CHOICES applicant: a person who is currently not a CHOICES member

- Change in current LOC: a person who is a current CHOICES member and his/her level of care needs have changed in any manner such that it is not reflected on the current PAE
- Current CHOICES member, current PAE ending: a person who is a current CHOICES member and his/her PAE is soon to end and the requestor believes CHOICES should continue

Diagnosis

Enter the full diagnosis that is relevant to the applicant's functional and/or skilled nursing needs. This diagnosis should also be found within the supporting documentation that is attached to the PAE.

Entering the PAE Request Date

This is the date you want the PAE to be effective. As part of the PAE approval process, TennCare will determine the PAE approval effective date and will use what you enter as part of their decision. See Chapter 15 to learn more about how TennCare determines a PAE approval effective date.

SUBMISSION OF THE HCBS PAE CERTIFICATION

HCBS PAE submissions require that the information on the certification form must match the information provided on the certification tab in The PAE Tracking System. For CHOICES HCBS Group 3 submissions, the name, credentials and assessor code must be provided on both the documentation tools and in the certification tab in The PAE Tracking System.

8.0 PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

This chapter provides information and guidance to facilitate the assessment or data collection, decision making, and PAE submission necessary for individuals applying for The Program of All-Inclusive Care for the Elderly, or Pace.

PACE is a managed care program providing frail elderly (age 55 and older) Medicare and Medicaid members with comprehensive and social services at an adult day center, at home, and/or inpatient facilities, using an interdisciplinary team and integrated care planning approach. For most participants, the comprehensive service package permits them to continue

living at home while receiving services, rather than an institution. PACE is currently available in Tennessee only in Hamilton County. Services are offered through the PACE Organization under contract with TennCare.

For persons applying for services through PACE, a referral should be made to the PACE Organization. PACE staff will complete a comprehensive assessment and submit the PAE to TennCare. PACE staff may also assist the person in filing their Medicaid application.

8.1 PACE MEDICAL NECESSITY OF CARE

Care is not provided in a Nursing Facility, but instead in the home or community setting. Rather than being expected to improve or ameliorate the individual's physical or mental condition, to prevent deterioration in health status, or to delay progression of a disease or disability, the purpose of PACE is primarily to allow the person to continue living safely in the community and to delay or prevent placement in a NF.

PACE requires a Physician's Order, for services:

- must be specified in an approved plan of care,
- must be needed by the individual *on an ongoing basis*.
- PACE and the PACE services **must be** required in order to allow the person to continue living safely in the home or community-based setting and to prevent or delay placement in a nursing facility.

MEDICAL NECESSITY OF CARE FOR INDIVIDUALS REQUESTING PACE

Care is not provided in a Nursing Facility, but instead in the home or community setting. Rather than being *expected to improve or ameliorate the individual's physical or mental condition, to prevent deterioration in health status, or to delay progression of a disease or disability*, the purpose of PACE is primarily to allow the person to continue living safely in the community and to delay or prevent placement in a NF. And, while PACE requires a Physician's Order and like NF services, must be needed by the individual *on an ongoing basis*. Thus, to satisfy medical necessity of care requirements for PACE, it must be determined that PACE services are required in order to allow the person to continue living safely in the home or community-based setting and to prevent or delay placement in a nursing facility.

8.2 NEED FOR INPATIENT CARE FOR PERSONS ELIGIBLE FOR NF CARE WHO ELECT PACE

The Person receiving PACE must have a physical or mental condition, disability or impairment (as determined by the functional assessment on the PAE). Such impairment does not necessarily require daily inpatient nursing care, but instead, must require ongoing supervision and assistance with activities of daily living in the home or community setting.

The individual must be unable to self-perform self-care and must:

- Have a total acuity score of at least 9 on the TennCare NF LOC Acuity Scale; or
- Meet “At Risk” LOC on an *ongoing basis* and be determined by TennCare to not qualify for enrollment in CHOICES Group 3 based on a Safety Determination.

PACE require the same level of care as Group 1.

8.3 NEED FOR INPATIENT CARE FOR PERSONS NOT ELIGIBLE TO RECEIVE CARE IN NF, BUT “AT RISK” OF NF PLACEMENT WHO REQUEST PACE

Like persons requesting PACE who meet NF LOC, persons requesting PACE who are “at risk” of NF placement must have a physical or mental condition, disability or impairment. Similarly, the person does not necessarily have to require daily *inpatient nursing care*, but instead, must require ongoing supervision and/or assistance with activities of daily living in the home or community setting. While services do not have to be required on a *daily* basis, the need for assistance must be ongoing such that the person would otherwise not be able to safely live in the community and would be at risk of placement in a NF in order to be eligible to receive HCBS.

The need for inpatient care as it relates to persons not eligible to receive care in a NF, but requesting PACE is as follows:

The member has a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. In the absence of such PACE services, the person would not be able to live safely in the community and would be at risk of NF placement. The individual must be unable to self-perform needed assistance and must have a significant deficit (needing assistance daily or at least four days per week) in an activity of daily living or related function as captured on the PAE application.

To qualify for PACE, a need for inpatient care requirement of NF LOC may be satisfied with either a total acuity score of 9 or a determination that a person who meets At Risk LOC does not qualify for enrollment into CHOICES Group 3.

8.4 LOC ACUITY SCALE

The total acuity score is calculated using the assessment of certain functional and clinical needs. The clinical needs as captured on the PAE are skilled and/or rehabilitative services (e.g., tube feeding, wound care, occupational therapy, physical therapy, ventilator care). The functional needs as captured on the PAE include the applicant's need for assistance with the following Activities of Daily Living (ADLs):

- Transfer;
- Mobility;
- Eating; and
- Toileting;

And deficits in the following ADL-related functions:

- Communication (expressive and receptive);
- Orientation (to person, place, or event/situation);
- Behaviors; and
- Self-administration of medications

The TennCare NF LOC Acuity Scale is attached. (Attachment A)

8.5 QUALIFICATIONS FOR ENROLLMENT IN PACE

A participant's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

1. An applicant must be dual eligible and in the target population (age 55 and older);
2. An applicant must have an approved unexpired PACE PAE for NF LOC;
3. An applicant must be approved financially for TennCare reimbursement of LTSS
4. Each enrollee shall have an individualized written plan of care that shall be developed within thirty (30) calendar days of enrollment in the PACE Program.

8.6 PACE PLAN OF CARE

This plan of care shall be person-centered and directed by the individual receiving services, or the individual's authorized representative, if applicable.

The plan shall also be understandable to the individual or his/her representative, including the use of plain language, and shall account for cultural considerations.

PACE Program services shall be provided in accordance with the plan of care.

Prior to the development of the plan of care, services shall be provided in accordance with the approved Pre-Admission Evaluation (PAE) and the physician's initial plan of care.

The plan of care shall include, but not be limited to, the following:

- (1) Diagnoses;
- (2) Medications, including the dosage, frequency, and route of administration for each;
- (3) Allergies;
- (4) Diets, including medically necessary special diets;
- (5) A description of the enrollee's current health status and functional and cognitive capabilities;
- (6) A description of health care services, identified through an assessment of functional need, and the amount, frequency (number of days per week), and duration (hours per day) of services and the type of provider to furnish each service, and the sites where such services are provided, which have been planned with regard to the individual or authorized representative's preferences;
- (7) A description of any environmental accessibility adaptations, specialized equipment and supplies, and/or assistive technology needed by the enrollee;
- (8) A description of the individual's social environment, including caregiver support;
- (9) Names of primary care providers;
- (10) Information about the use of Personal Emergency Response Systems;
- (11) Strategies for solving conflict disagreements;
- (12) A method to request updates; and
- (13) Risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

REVIEW OF PACE PLAN OF CARE

Members of the interdisciplinary team shall review the plan of care when needed, but no less frequently than every one hundred eighty (180) calendar days, in order to update the plan of care.

Members of the team shall indicate that the plan of care has been reviewed and updated by dated signatures.

The review by members of the team shall include, but not be limited to:

- reviewing outcomes and determining if progress is being made in accordance with the plan of care;
- reviewing the appropriateness of supports and services provided and their sources and discussing whether alternatives should be sought; and,
- reviewing information related to observation, discussion, and assessment.

8.7 TRANSITIONING BETWEEN PACE AND CHOICES

When a member voluntarily transitions from PACE to CHOICES or vice versa, it's important to take additional measures to both limit service disruption and avoid the duplication of services. Key to minimizing any potential negative consequences is communication and collaboration between the MCO and PACE. Once a member has initiated the desire to transition, the transitioning from entity (PACE or the MCO, as applicable) should immediately contact the transitioning to entity (PACE or the MCO, as applicable) to help plan for the transition. This includes coordinating care during the transition process, identifying potential barriers and risks that may occur in transition, and working to develop and implement strategies to eliminate barriers and minimize risks. The MCO and PACE will work together to answer the member's questions about the transition process. Once it is determined that the member is ready to transition, the transitioning from entity (PACE or the MCO, as applicable) will complete the TennCare form necessary to process the transition and submit it to the TennCare CHOICES mailbox.

When a transition request is received, TennCare LTSS will review the request, interface with both the MCO and PACE as necessary to confirm coordination and then process the transition. If at any time criteria is not met to transition the member, notification will be sent to both PACE and the MCO. If the transition involves a move from NF to HCBS or vice versa, TennCare LTSS will work with TennCare Member Services to recalculate the member's Patient Liability obligation amount. A PASRR is required for PACE participants that are transitioning to CHOICES in a NF.

8.8 ADDITIONAL ENROLLMENT INDICATORS

CHOICES and PACE "carry over" group ("Grandfathered"):

For applicants who qualified for and were enrolled in CHOICES or PACE prior to July 1, 2012, only one significant deficit in any of the above areas was sufficient to satisfy the need for inpatient care provision of NF LOC eligibility. These individuals are in the "carry over" group and have an enrollment status that is referred to as "grandfathered."

Documentation regarding these individuals are found in the TennCare Medicaid Management Information System (MMIS—also called Interchange). TennCare eligibility and enrollment information is sent to Managed Care Organizations from the MMIS and provided to PACE staff and service providers via TN Anytime. TennCare relies on the MMIS and other safeguards to ensure that the correct standards are applied when determining level of care. TennCare’s federal partners at the Centers for Medicare and Medicaid Services (CMS) approved allowing TennCare to grandfather existing NF residents and those already receiving home-based care so long as they continue to meet the LOC criteria in place at the time of enrollment and remain continuously eligible and enrolled in the CHOICES Group or PACE, as applicable.

8.9 PACE PAE ASSESSMENTS

Now that you are familiar with PACE and have an understanding of eligibility and enrollment criteria, we will introduce the process for completing a PAE application so that TennCare may determine level of care, or medical eligibility for PACE. Remember, for an applicant to qualify for CHOICES PACE, NF LOC must be approved. To qualify for CHOICES Group 3, At Risk LOC must be approved.

WHO CAN COMPLETE A PACE PAE ASSESSMENT?

For PACE PAEs, assessors are clinically trained staff (employed by a PACE Organization, who have completed a TennCare training about LTSS Programs and the PACE PAE application process. The assessor must be RN, LPN or LSW

PACE PAE CERTIFICATION

For all PAEs, the clinical assessor must certify that the level of care information provided on the PAE is accurate. Assessors must also acknowledge that they understand that the information provided is being used to determine Medicaid eligibility and/or reimbursement for long-term services and supports and that any intentional act to provide false information that would potentially result in a person obtaining benefits or coverage that he or she is not entitled to is considered an act of fraud under the State’s TennCare program and Title XIX of the Social Security Act. This certification is captured in The PAE Tracking System on the Certification Tab. The PAE Certification Form is signed and dated by the LOC certifier and is included with the PAE application as an attachment in The PAE Tracking System. Sometimes a physician, PA, NP, APN, RN, LPN LSW, or TennCare Qualified Assessor allows a PAE to be completed and submitted in The PAE Tracking System by someone else on his/her behalf. In these cases, RN, LPN, LSW, continues to assume all responsibility for ensuring that the information as submitted is accurate.

COMPONENTS OF THE PACE PAE ASSESSMENT

Remember, there are two components of level of care (LOC) eligibility:

- Medical necessity of care; and
- Need for inpatient care.

The functional assessment and supporting medical evidence included with the PAE application are used to determine if the Need for Inpatient Care requirement is satisfied when determining LOC.

For both CHOICES and PACE, Level of Care (**LOC**) is one of two eligibility components (the other being financial eligibility) for Medicaid reimbursement of long term services and supports. PAE applications are submitted to TennCare using a web based software application known as The PAE Tracking System).

INTERVIEWING PROCESS FOR A PACE PAE

The preferred source of information is the client. If there is another person in the room when the client is being interviewed, questions should continue to be directed to the client. If others who are present try to answer questions for the client, they should be asked not to assist with responses or provide reminders or hints. They will be given the opportunity to complete their own interview.

Other sources of information, such as the primary care giver, family members, other helpers, friends, neighbors and/or provider staff should also be used. For the completion of some sections of the assessment, the assessor may need to interview other professional staff such as physicians, nurses, or social workers. Also, it may be necessary to obtain a translator or some other spokesperson for the individual. It will be important to know ahead of time if possible, to prepare for the interview beforehand.

Although it is recommended, it is not necessary to seek information in the exact order in which appears on the form. The form is designed with a logical flow and is intended to appear reasonable to the applicant. However, because applicants will present information in their own way, it is not necessary to ask questions which have already been answered in the course of the interview, just record the answer already given.

ASKING QUESTIONS FOR A PACE PAE

A good clinical interviewer is always on the lookout for both themes and discrepancies. Themes help you note and describe patterns across time. These patterns may be critical to understanding both how to leverage the person's strengths and to understand how best to support the person to prevent patterns of difficulties. An assessor should never lead the respondents toward a particular answer but is encouraged to ask for descriptions and clarifications that will help the respondent or the assessor to resolve discrepancies or inconsistencies in the information being received. Being alert for discrepancies

to conflicting reports ensures that the assessor gets clarification to clarify promptly when information just doesn't add up.

It is important that the assessor avoids using "buzz words", generalizations, or reporting opinions instead of descriptions and observations. Provide objective, extensive and clear descriptions of the person's medical, functional and behavioral status. When describing behavioral symptoms, remember that the same behavioral symptoms can present very differently for each person. One person's experience of "agitated" can involve violent or aggressive behaviors, while another person's experience may involve irritability, lack of sleep and extreme restlessness. It is important to describe in detail what behaviors, support needs, etc. look like for that person. Tell the story of their current presentation.

Ensure the assessment form provides a clear, detailed and consistent picture of the individual's functional status.

The best guidance for a great clinical interview is to collect individualized, detailed information from a variety of sources to ensure that the individual's unique needs and characteristics are reflected. The quality of this process is directly correlated to the quality of the clinical interview.

8.10 PAE FUNCTIONAL ASSESSMENT

Now that you understand who can perform assessments it's important for all submitters to understand how to complete the functional assessment on the PAE. Remember, there are two components of level of care (LOC) eligibility:

- Medical necessity of care; and
- Need for inpatient care.

Both of these components apply to Nursing Facility LOC and At Risk LOC. The functional assessment and supporting medical evidence included with the PAE application are used to determine if the Need for Inpatient Care requirement is satisfied when determining LOC.

First, we'll walk through how to measure levels of functional deficit on the PAE. Next, we'll cover each functional area and the applicant's need for assistance. Then we'll explain how the need for skilled and/or rehabilitative services is documented on the PAE.

Measuring Functional Deficits

On the PAE, there are 4 possible responses to each question. *Except* for behavior, "**Always**" means that the applicant is **always independent** with that ADL or related activity. "**Usually**" means that the person is **usually independent** (requiring assistance fewer than 4 days per

week). **“Usually not”** means that the applicant is usually not independent (requiring assistance 4 or more days per week). **“Never”** means that the applicant is **never independent** with that ADL or related activity.

With respect to behavior, the responses are reversed. **“Always”** means that the applicant always requires intervention for behaviors. **“Usually”** means that the applicant requires intervention for behaviors 4 or more days per week. **“Usually not”** means that the applicant requires intervention for behaviors, but fewer than 4 days per week. **“Never”** means that the applicant does not have behaviors that require intervention.

TennCare has assigned a weighted value to each of the possible responses to each question on the PAE, based on the amount of assistance that would be required for a person with that type and level of ADL or related deficit. The TennCare NF LOC Acuity Scale (Attachment A) provides the weight given to each functional measure and response. Each response must be supported by the medical evidence submitted with the PAE in order for the assigned acuity score to be approved by TennCare.

ADLs and ADL-related functions

When providing responses to each functional measure as indicated on the functional assessment, you should consider the act of physical assistance being "hands on" care. You should also consider a person's functionality in a 24 hour/7 days a week window of need. Some patients may appear, during your presence, to be functioning well in an area that they may not function well at in different times/days. For example, someone may be only incontinent at night, but continent the rest of the day. When these types of situations exist, it is important to clearly explain it on the PAE as a note or comments in The PAE Tracking System.

I. Transfer

DEFINITION: Transfer - The applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis.

QUESTION ON PAE: Can applicant transfer to and from bed, chair or toilet without physical help from others?

HELPFUL HINT: This is moving the body from one place to another without ambulating (which is covered under the Mobility section). It is important to note the definition applies to bed, chair, or toilet only. An example may be that the applicant needs someone to hold onto him to successfully get up/down from the bed and on/off the toilet.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of transfer to and from bed, chair, or toilet without physical assistance from others.
- Usually: Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of transfer to and from bed, chair, or toilet without physical assistance 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit requires documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of transfer assistance required.

*Recommended documentation to support this functional deficit: medical **H**istory and **P**hysical (**H&P**), ADL flow sheets, PT notes, nurse's notes, section "G" of **Minimum Data Set (MDS)***

II. Mobility

DEFINITION: Mobility - The applicant requires physical assistance from another person for mobility on an ongoing basis. Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair (manual or electric) if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

QUESTION ON PAE: Can applicant walk without physical help from others?

HELPFUL HINT: This is the act of moving from one place to another. In other words, if someone is able to get from one place to another using their manual or power wheelchair, this would be considered "mobile". An example may be that the applicant needs someone to hold on to him when he is ambulating with his cane.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of walking without physical assistance.
- Usually: Applicant is incapable of walking unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable walking unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of walking without physical assistance 7 days per week.

Only when the above question is answered with a **UN** (Usually Not) or **N** (Never), follow to the next question under Mobility:

QUESTION ON PAE: If walking is not feasible (answer to mobility question above is UN or N), is Applicant capable of using a wheelchair, either manual or electric?

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of mobility without physical assistance.
- Usually: Applicant is incapable of wheelchair mobility unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of wheelchair mobility unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of wheelchair mobility without physical assistance 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of mobility assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, PT notes, nurse’s notes, section “G” of MDS

III. Eating

DEFINITION: Eating - The Applicant requires physical assistance with gastrostomy tube feedings or physical assistance or constant one-on-one observation and verbal assistance (reminding, encouraging to consume prepared food and drink or self-administer tube feedings, as applicable) or must be fed part or all of each meal. Food preparation, tray set-up, assistance in cutting up foods, and general supervision of multiple residents shall not be considered to meet this requirement.

QUESTION ON PAE: Can applicant eat (or physically self-administer tube feeding as applicable) without help from others?

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of eating without help from others.
- Usually: Applicant is incapable of eating without help from others 1-3 days per week.
- Usually Not: Applicant is incapable of eating without help from others 4-6 days per week.
- Never: Applicant in never capable of eating without help from others 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation which supports the need for such intervention, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task. For PAEs submitted by the AAAD (or entity other than an MCO, NF, or PACE Organization), an eating or feeding plan specifying the type, frequency and duration of supports required by the Applicant for feeding, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the Applicant would be unable to self-perform this task shall be required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, OT/ST notes, nurse's notes, swallow study, section "G" of MDS

IV. Toileting

DEFINITION: Toileting - The applicant requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or catheter care on an ongoing basis

QUESTION ON THE PAE: Can applicant toilet without physical assistance from others?

HELPFUL HINT: Includes the act of toileting, adjusting clothing and/or being able to properly clean oneself. This does NOT include the act of getting on/off the toilet as this is accounted for in the Transfer question. Incontinence is scored separately, for example someone may usually be able to toilet but is incontinent and can never clean themselves. Some people can have an indwelling catheter and care for it themselves, do not assume the presence of one means the person is never able to self-care. An example may be the applicant needs someone to clean him/herself and help him/her pull up their pants and buckle their pants belt after toileting.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of toileting without physical assistance.
- Usually: Applicant is incapable of toileting unless physical assistance is provided by others 1-3 days per week.
- Usually Not: Applicant is incapable of toileting unless physical assistance is provided by others 4-6 days per week.
- Never: Applicant is never capable of toileting without physical assistance 7 days per week.

Only when the applicant is incontinent, follow to the next question under Toileting:

QUESTION ON THE PAE: Can applicant perform incontinent care without physical assistance from another person on an ongoing basis?

- Always: Applicant is always capable of performing incontinence care without physical assistance.
- Usually: Applicant is incapable of performing incontinence care and requires physical assistance 1-3 days per week.
- Usually Not: Applicant is incapable of performing incontinence care and requires physical assistance 4-6 days per week.
- Never: Applicant is never capable of performing incontinence care and requires physical assistance 7days per week.

Mark the type of incontinence, Bowel or Bladder.

Only when the applicant has a catheter or ostomy present, follow to the next question under Toileting:

QUESTION ON THE PAE: Can applicant perform catheter/ ostomy care without physical assistance from another person on an ongoing basis?

- Always: Applicant is always capable of performing catheter/ ostomy care without physical assistance.
- Usually: Applicant is incapable of performing catheter/ ostomy care and requires physical assistance 1-3 days per week.
- Usually Not: Applicant is incapable of performing catheter/ ostomy care and requires physical assistance 4-6 days per week.
- Never: Applicant is never capable of performing catheter/ ostomy care and requires physical assistance 7days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific type and frequency of toileting assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ADL flow sheets, nurse's notes, section "G" of MDS

V. Orientation

DEFINITION: Orientation - The applicant is disoriented to person (e.g., fails to remember own name, or recognize immediate family members), place (e.g., does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make good decisions that prevent risk of harm)

QUESTION ON PAE: Is applicant oriented to person (remembers name; recognizes family), place (does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make decisions that prevent risk of harm)?

HELPFUL HINT: Please note the definition for orientation to person, place and/ or event/situation only; this does NOT include such things as time, or people who are not immediate family. An example may be the applicant does not know who he/she is and/or where he/she is.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always oriented to person, place and event/situation.
- Usually: Applicant is disoriented to person or place or event/situation 1-3 days per week.
- Usually Not: Applicant is disoriented to person or place or event/situation 4-6 days per week.
- Never: Applicant is never oriented to person or place or event/ situation 7 days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific orientation deficits(s), including the frequency of occurrence of such deficit(s), and the impact of such deficit(s) on the Applicant.

*Recommended documentation to support this functional deficit: H&P, plan of Care, Nurse's notes, psych notes, **Mini- Mental Status Exam (MMSE)**, **Saint Louis University Mental Status (SLUMS)***

VI. Communication

DEFINITION: Expressive and Receptive Communication - The Applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including through the use of assistive devices; or the Applicant is incapable of understanding and following very simple instructions and commands without continual intervention

HELPFUL HINT: Communication includes basic information; not complex instructions or complex needs/wants. Possibly ask the person to raise their hands over their head. This would not be to assess movement, but to assess if the person can follow simple instruction. An example may be that the applicant needs help to let others know that he/she needs to use the toilet.

QUESTION ON PAE: The applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including through the use of assistive devices.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of reliably communicating basic needs and wants.
- Usually: Applicant is incapable of reliably communicating basic needs and wants and requires continual intervention 1-3 days per week.
- Usually Not: Applicant is incapable of reliably communicating basic needs and wants and requires continual intervention 4-6 days per week.
- Never: Applicant is never capable of reliably communicating basic needs and wants and requires continual intervention 7 days per week.

QUESTION ON PAE: The applicant is incapable of understanding and following very simple instructions and commands without continual intervention.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of understanding and following very simple instructions and commands without continual intervention.
- Usually: Applicant is incapable of understanding and following very simple instructions and commands without continual intervention 1-3 days per week.
- Usually Not: Applicant is incapable of understanding and following very simple instructions and commands without continual intervention 4-6 days per week.
- Never: Applicant is never capable of understanding and following very simple instructions and commands without continual intervention 7days per week.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of communication assistance required.

Recommended documentation to support this functional deficit: H&P, Plan of Care, ST notes, Nurse’s notes, psych notes, MMSE, SLUMS

VII. Medications

DEFINITION: Medication Administration - The Applicant is not cognitively or physically capable of self-administering prescribed medications at the prescribed schedule despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to Applicant, reassurance of the correct dose, and the use of assistive devices including a prepared medication box. An occasional lapse in adherence to a medication schedule shall not be sufficient for approval of this deficit; the Applicant must have physical or

cognitive impairments which persistently inhibit his or her ability to self-administer medications.

QUESTION ON PAE: Is applicant physically or cognitively able to self-administer medications with limited assistance from others (as described above)?

HELPFUL HINT: This includes physician prescribed PO, IM, RX Otics, Ophthalmics, Topicals, Inhalers, Continuous SQ (subcutaneous) Medications, and SQ Injections excluding SS sliding scale insulin.

MARK THE ACCURATE ANSWER:

- Always: Applicant is always capable of self-administration of prescribed medications.
- Usually: Applicant is incapable of self-administration of prescribed medications without physical intervention 1-3 days per week.
- Usually Not: Applicant is incapable of self-administration of prescribed medications without physical intervention 4-6 days per week.
- Never: Applicant is never capable of self-administration of prescribed medications without physical intervention 7 days per week.

Only when the above question is answered with a **UN** (Usually Not) or **N** (Never), you must list, on the PAE, the medications for which assistance is needed, and provide explanation regarding why applicant is unable to self-administer with limited help from others.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require evidence that such interventions have been tried or would not be successful, and that in the absence of intervention, the Applicant's health would be at serious and imminent risk of harm.

Recommended documentation to support this functional deficit: H&P, Plan of Care, order/prescription for medications listed as unable to self-administer, Medication Administration Record (MAR), Nurse's notes, Speech Therapy (ST) notes

VIII. Behavior

DEFINITION: Behavior - The Applicant requires persistent staff or caregiver intervention and supervision due to an established and persistent pattern of behavioral problems which are not primarily related to a mental health condition (for which mental health treatment would be the most appropriate course of treatment) or a substance abuse disorder (for which substance abuse treatment would be the most appropriate course of treatment), and which, absent such continual intervention and supervision, place the Applicant or others at imminent and serious risk of harm. Such behaviors may include physical aggression (including assaultive or self-injurious behavior, destruction of property, resistive or combative to personal and other care,

intimidating/threatening, or sexual acting out or exploitation) or inappropriate or unsafe behavior (including disrobing in public, eating non-edible substances, fire setting, unsafe cooking or smoking, wandering, elopement, or getting lost).

QUESTION ON PAE: Does applicant require persistent intervention for an established and persistent pattern of behavioral problems not primarily related to a mental health or substance abuse disorder?

HELPFUL HINT: Notice answers are in reverse from previous options, “Always” referring to the person requires intervention. An example may be the applicant needs someone to intervene daily when he/she attempts to strike their caregiver.

MARK THE ACCURATE ANSWER:

- Always: Applicant always requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 7 days per week.
- Usually: Applicant requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 4-6 days per week.
- Usually Not: Applicant requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 1-3 days per week.
- Never: Applicant never requires persistent intervention due to an established and persistent pattern of behavioral problems.

When the above question is answered with an **A** (Always) or **U** (Usually), you must document and specify, on the PAE, the behavioral problems requiring continual staff or caregiver intervention.

SUPPORTING DOCUMENTATION: TennCare approval of this deficit shall require documentation of the specific behaviors and the frequency of such behaviors.

Recommended documentation to support this functional deficit: H&P, Plan of Care, nurse’s notes, psych notes

8.11 DOCUMENTATION TO SUPPORT THE PACE PAE

All PAE submissions are required to have specific supportive documentation reflecting the deficits as identified on the PAE. This documentation will be reviewed by TennCare and compared to the PAE and functional deficits as listed when determining LOC. If supportive documentation is not attached to the PAE according to specifications, LOC may be denied.

The following are required attachments to a PACE PAE submission:

- MD Certification of medical necessity for PACE;
- A recent History and Physical (completed within 365 days of the PAE Request Date or date of Physician Certification, whichever is earlier) AND/OR other recent medical records from a MD or advanced practitioner who provided the medical diagnoses which support the applicant's functional and/or skilled nursing or rehabilitative needs;
- Certification of the level of care assessment by an Assessor shall be required for all PAEs; and
- HCBS documentation tools (applicant and collateral tools) are optional to be completed and submitted with all PACE PAEs (attachment D&E).

MD CERTIFICATION FOR PACE REQUESTS

For PACE applicants, the medical necessity provision of NF LOC is satisfied through Physician, MD or DO (or PA, NP, APN as applicable) signature and printed name on the PAE certification form (Attachment C).

- This form is also be printed from the homepage of the The PAE Tracking System online portal.
- The most recently updated form must be used and attached to the PAE.
- An original physician's signature is required when submitting a PAE and any revisions or recertifications (detailed in 5.7)
- PAEs will not be approved for NF LOC unless the certification form is filled out in its entirety and the physician, MD or DO (or PA, NP, APN as applicable) has signed the statement on the PAE Certification page certifying the applicant requires the level of care provided in a nursing facility and that the requested long term care services are medically necessary for the applicant.
- The information on the certification page must match that provided in the certification tab in The PAE Tracking System.
- Anytime, it appears that a Certification Signature is duplicated or not an original signature, a referral to TennCare's Program Integrity Unit must be made.

8.12 PACE PAE SUBMISSION

PACE PAE submissions require that the information on the certification form must match that information provided on the certification tab in The PAE Tracking System. For PACE PAE submissions, the MD certification and NPI number is required. The name of the assessor entered into the PAE Tracking System must match the signed and dated applicant assessment

form.

8.13 RECERTIFYING A PACE PAE

A PACE enrollee must continue to meet the *medical* eligibility criteria for nursing facility level of care or be determined that he or she will meet level of care criteria within six (6) months in the absence *of* continued coverage of PACE services.

At least annually, the Grantee must submit a completed Pre-Admission Evaluation (PAE) recertification form thirty (30) days prior to the recertification due date for each enrollee.

Determination that a PACE enrollee will meet level of care criteria within six (6) months will be based on the individual's ability:

- (1) The individual's ability to remain compliant with medication(s) required for treating the individual's medical condition(s).
- (2) The individual's ability to remain compliant with a specialized *diet* necessary for prevention of complications related to the individual's medical condition(s).
- (3) The individual's ability to maintain mobility (including transfer) without physical assistance from others.
- (4) The individual's ability *to* maintain independence with activities *of* daily living.

The Bureau of TennCare *will* waive the annual recertification requirement if it is determined that there is no reasonable expectation *of* improvement or significant change in *the* enrollee's condition, due to the severity *of* a chronic condition or the degree of impairment of functional capacity. The recertification requirement may be waived during any annual recertification period after one (1) year of enrollment. The medical conditions for which the annual recertification requirement may be waived include, but are not limited, to the following:

- (1) Diagnosis of Alzheimer's disease or related dementia.
- (2) Ongoing chronic conditions requiring routine monitoring such as Chronic Obstructive Pulmonary Disease, End Stage Renal disease, Congestive Heart Failure.
- (3) Disease processes that have a decreased likelihood for improvement or high risk of progress toward deterioration.

The Bureau of TennCare will provide written notification to the Grantee indicating that the recertification requirement has been waived indefinitely and the reason(s) for the waiver. The Grantee shall retain the waiver notification in the enrollee's medical record.

The Grantee shall have the right to contest TennCare decisions pursuant to the provisions of Tennessee Code Annotated (TCA).

9.0 INTERMEDIATE CARE FACILITY—INDIVIDUALS WITH INTELLECTUAL DISABILITIES (IFC-IID)

The Intermediate Care Facilities for Individuals with Intellectual Disabilities and Intellectual Disability Waiver Programs were established for individuals with a diagnosis of intellectual disability (ID) prior to the age 18. The individual must qualify financially for Medicaid services as determined by TennCare member services. And, to receive TennCare reimbursed long term services and supports (LTSS) an individual must meet medical eligibility criteria for the applicant type of institutional care as determined by TennCare. Medical eligibility, or level of care (LOC) is largely based on functional deficits in a person's ability to perform Activities of Daily Living.

9.1 IFC-IID MEDICAL NECESSITY OF CARE

In order for care in an ICF-IID to be considered medically necessary, it must be ordered and supervised by a physician. Care in an ICF-IID must also be expected to enhance the individual's functional ability or to prevent or delay the deterioration or loss of functional ability. If the attachments do not contain the MD Order, the ICF-IID PAE is denied with instruction to the submitter to revise the PAE and attach the MD Order.

9.2 QUALIFICATIONS FOR ENROLLMENT IN IFC-IID

A. DIAGNOSIS OF INTELLECTUAL DISABILITY

Intellectual disability is defined as significantly sub average general intellectual functioning, indicated by a Full Scale Intelligence Quotient (FSIQ) score of 70 or below, existing concurrently with deficits in adaptive behavior which are manifested during the developmental period (prior to Age 18).

The diagnosis is made by a psychological examination including a full scale I.Q. and the person's current level of functioning performed by a:

- A Licensed Psychologist; or
- A Licensed Senior Psychological Examiner (LSPE) supervised by a Licensed Psychologist that is conducted prior to admission to the ICF-IID or authorization of payment, but not more than three months prior to admission. A psychological examination performed more than three months

prior to admission may be updated by the qualified professional who completed the assessment or if completed by a LSPE, by the supervising Licensed Psychologist.

There is no time limit for the psychological evaluation as long as:

- It is completed prior to the submission of the PAE
- The person's current medical, social, developmental and psychosocial history continues to support the evaluation.

A new psychological evaluation performed within ninety (90) calendar days preceding the date of admission into the waiver is required if the person's condition has significantly changed, or the original evaluation is not otherwise consistent with the person's current medical, social, developmental and psycho-social history.

EVIDENCE TO SUPPORT ID DIAGNOSIS PRIOR TO 18

Evidence to support the diagnosis of ID prior to 18 in order of preference may include:

1. A Psychological Examination performed prior to the age of 18 by a
 - a.) Licensed Psychologist; or
 - b.) LSPE supervised by a Licensed Psychologist prior to the age of 18
2. A Level II PASRR evaluation performed prior to age 18 that includes testing and a Full Scale Intelligence Quotient
3. A school psychological performed and signed by a licensed professional
4. School records documenting a diagnosis of intellectual disability or evidence of placement in special education combined with evidence of substantial impairments in adaptive functioning during the developmental period
5. Medical records documenting intellectual disability or a condition with a high probability of resulting in intellectual disability combined with evidence of substantial impairments in adaptive functioning during the developmental period
6. If a person is older and no testing has ever been done, records are no longer kept, or records can't be located, a combination of the following may be used as proof of ID:
 - a current psychological examination or psychological examination completed after the age of 18
 - school records

- phone interviews or written statement from family members, friends, conservator or guardian who have direct knowledge of the applicant's functioning during the developmental period and who attest to specific substantial impairments in adaptive functioning during the developmental period, mental incapacity evidenced by dependence upon others for personal needs (grossly in excess of age-appropriate dependence), and/or the inability to successfully participate in regular education and/or post education employment without interventions or supports.

BURDEN OF PROOF OF ID DIAGNOSIS

The applicant has the burden of proof for establishing onset of ID prior to age 18. Conflicting information shall be weighted in accordance with the level of evidence provided.

- Conflicting IQ scores both above and below the maximum threshold of 70 shall be given equal weight, such that additional evidence would be required to establish onset prior to age 18.
- An IQ score of 71 or above prior to age 18 shall be given greater weight than attestations provided by family members or others.
- Attestations by family members or friends of substantial impairments in adaptive functioning during the developmental period shall not be sufficient to support onset prior to age 18 when the person obtained a high school diploma or has successfully participated in post-education employment

B. SIGNIFICANT DEFICIT OR IMPAIRMENT IN ADAPTIVE FUNCTIONING

A recent medical history and physical, which according to TennCare Rule 1200-13-01-.15(2)(d), must be performed within 365 days of the ICF-IID PAE Request Date and may be used as long as the individual's condition has not changed significantly. Other medical records may be used to supplement a history and physical and provide current medical information if changes have occurred since the history and physical was performed. The history and physical must be signed by a licensed physician (MD or DO), PA, NP, or APN. The following information should be addressed either on the PAE and/or on the attached physical examination:

- Assessment of capabilities and needs

- The Plan of Care section of the PAE should specify the specific waiver services necessary for the person including the frequency and duration of each waiver service needed for the first 30 days. (Only these services are provided within the first 30 days of PAE approval. After that period, the enrollee's Independent Support Coordinator can add or delete services.)

C. NEED FOR SPECIALIZED SERVICES FOR ID

- Certification of the Assessment by a Qualified Assessor
- Physician certification of the PAE
- Physician order for ICF-IID services or for ID Waivers, Initial Plan of Care specifying the Waiver services needed by the applicant

9.3 ICF-IID MEDICAL CERTIFICATION

Medical necessity of care is determined and certified by a physician and the PAE must include such certification along with a signed order for ICF-IID care. This is done by reviewing of the attachments in The PAE Tracking System. If the attachments do not contain the MD Order, the ICF-IID PAE is denied with instruction to the submitter to revise the PAE and attach the MD Order.

9.4 ICF-IID PAE ASSESSMENTS

The LTSS Nurse reviews the ICF-IID PAE to identify: Medical Necessity of Care; Diagnosis of ID; Significant deficit or impairment in adaptive functioning; and, need for specialized services for ID. The PAE functional assessment, need for habilitative services and supporting medical documentation are reviewed to determine if the individual meets the specified LOC for the services requested.

WHO CAN COMPLETE AN ICF-IID PAE?

PAEs assessors are clinically trained staff (employed by PACE Organization, an MCO or AAAD) who have completed an in person TennCare training about LTSS Programs and the ICF-IID application process. The assessor must be a Physician (MD or DO), Physician Assistant (PA), Nurse Practitioner (NP), Advanced Practice Nurse (APN), Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Social Worker (LSW). All assessors must be TennCare Qualified Assessors.

DOCUMENTATION TO SUPPORT THE ICF-IID PAE

The PAE functional assessment, need for habilitative services and supporting medical documentation is reviewed to determine if the individual meets the specified LOC for the services requested.

Each ICF-IID PAE must include physician certification, a history and physical, psychological examination, proof of onset of ID prior to age 18 and other relevant information.

A PAE response indicating the deficit(s) or impairment(s) certified by a Qualified Assessor and supported by a recent medical history and physical signed by a physician who is licensed as an MD, DO, Licensed NP or PA medical history and physical performed within 365 calendar days of the ICF-IID PAE Request Date may be used if the individual's condition has not significantly changed.

Additional medical records (progress notes, office records, discharge summaries, etc.) may be used to supplement a history and physical in order to support the specific deficit/impairment(s) and to provide current medical information if changes have occurred since the history and physical was performed.

For behavior (of such severity that the absence of an ongoing program of behavior modification therapy would reasonably be expected to seriously endanger the life of the person, resolute in severe self-inflicted injury, cause severe injury to others, or seriously endanger the lives of others), supporting documentation of the specific behaviors, the frequency of such behaviors, and the imminence and seriousness of risk is required.

ICF IID PAE CERTIFICATION

Each PAE assessment must be certified by a qualified assessor. This is done by reviewing the Certification tab in TPAES. If the Certification Tab does not contain the certification of the assessment by a qualified assessor, the ICF/IID PAE is denied with instruction to the submitter to revise the PAE and accurately complete the Certification Tab.

9.5 DETERMINING ICF-IDD PAE EFFECTIVE DATES

The effective date of the PAE may be the request date or physician certification date, whichever is earlier, keeping in mind the following:

- A PAE effective date may not be greater than ten (10) days prior to the date of submission. If a PAE request date is more than 10 days before the date

of submission, the request date used by the PAE Reviewer should be a date of 10 days prior to submission.

- A Recertified PAE may be approved using a date not prior to the original effective date of the PAE so long as the end date of the original PAE has not expired.
- If a retro-active Department of Human Services (DHS) eligibility determination is submitted within thirty (30) days of a retro-active DHS eligibility determination notice, the effective date can go back as far as the original PAE effective date.

An approved PAE that has not been used within 90 calendar days from the PAE approval date can be updated within 365 calendar days of the PAE approval date if the physician certifies that the person's current medical condition is consistent with that described in the originally approved PAE. A PAE that is not used within 365 days of the initial approval date is expired and cannot be updated.

9.6 ICF-IDD PAE SUBMISSION

All ICF-IDD PAEs will be submitted to the PAE Unit through the TPAES system.

9.7 ICF-IDD APPEALS

If the ICF-IDD PAE is denied a denial letter is issued to the person and the designee, including information about appeal rights. Complete Information regarding appeals is found in Chapter 18.

10.0 CHOICES GROUPS 1,2,3 AND PACE TRANSITIONS

At times it may be necessary for an individual to move from one CHOICES Group or PACE to another level of care. This chapter provides direction to facilitate transitions for CHOICES 1, 2, 3 and PACE. Additional information to support transitions is provided in the chapters addressing each level of care.

Transition from CHOICES Group 1 to Group 2:

An MCO may request to transition a member from Group 1 to Group 2 only when the member chooses to transition from the NF to a home and community based setting. Members shall not be required to transition from Group 1 to Group 2. Only an MCO may submit to TennCare a request to transition a CHOICES member from Group 1 to Group 2. A member that has already been discharged from the NF shall not be transitioned to CHOICES Group 2. Once a member has been discharged from the NF, he/she has voluntarily dis-enrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 2. A new HCBS PAE shall be required for enrollment into CHOICES Group 2. When members move from Group 1 to Group 2, TennCare Member Services must recalculate the member's Patient Liability.

Transition from CHOICES Group 2 to Group 1:

An MCO may also request to transition a member from Group 2 to Group 1 only if the member meets NF LOC criteria, has completed the PASRR process, has a physician order for NF Care, the member is found to be NF appropriate, and at least one (1) of the following is true:

- (i) The member chooses to transition from HCBS to NF, for example, due to a decline in the member's health or functional status, or a change in the Member's natural care giving supports; or
- (ii) The MCO has made a determination that the member's needs can no longer be safely met in the community and at a cost that does not exceed the average cost of NF services for which the member would qualify, and the member chooses to transition to the more appropriate institutional setting in order to safely meet his/her needs.

When members move from Group 2 to Group 1, TennCare Member Services must recalculate the member's Patient Liability. A new NF PAE is always required if the member is enrolled as a "grandfathered" Group 2 member.

If member is found to have a PASRR condition, a new LOC screen will be required as part of the PASRR level II process. These transitions must be reviewed by a nurse to ensure all criteria are met. An appropriate PASRR and signed certification is required.

Transition from CHOICES Group 1 or Group 2 to Group 3:

TennCare or the MCO shall, subject to eligibility and enrollment criteria, initiate a transition from Group 1 or 2 to Group 3 when a member who was enrolled in CHOICES Group 1 or Group 2 on or after July 1, 2012 no longer meets NF LOC but meets At Risk LOC. A member that has already been discharged from the NF shall not be transitioned from CHOICES Group 1 to CHOICES Group 3. Once a Member has discharged from the NF, he has voluntarily dis-enrolled from CHOICES Group 1 and must be newly enrolled into CHOICES Group 3. In these instances,

the member must qualify for SSI at the time of transition and a new HCBS PAE shall be required for enrollment into CHOICES Group 3.

When a member transitions from CHOICES Group 1 to Group 3 TennCare Member Services must recalculate the Member's Patient Liability. The member must also qualify as an SSI recipient at the time of transition. By having SSI Medicaid is determined that member will have \$0.00 patient liability, therefore TennCare Member services does not need to recalculated PL.

Transition from CHOICES Group 3 to Group 1 or Group 2:

TennCare or the MCO shall initiate a transition from Group 3 to Group 1 or Group 2, as appropriate; when the member meets NF LOC and satisfies all requirements for enrollment into the requested Group (see requirements for the group requested). When a member transitions from Group 3 to Group 1, TennCare Member Services must recalculate the member's Patient Liability.

Transitions based on safety:

For existing CHOICES members, assessments are completed by the MCO annually and upon a change of the member's status/ condition. If at any time the MCO determines that the member's needs can no longer be safely met in the current care setting, the MCO may initiate and submit to TennCare a request for a safety determination as described in TennCare Rule. This determination must be made considering all covered services and supports available within either the individual's cost neutrality cap for Group 2 members, or expenditure cap for Group 3 members. TennCare must approve the MCO's request to transition due to safety and/or cost neutrality once the requirements for transition have been met. If a member does not wish to transition to another CHOICES Group so that his needs can be safely met, the MCO may initiate CHOICES disenrollment proceedings.

Transition information for NFs:

Nursing Facilities and other providers cannot initiate a CHOICES transition for CHOICES members. When a nursing facility believes that a CHOICES HCBS member requires a transition to receive TennCare reimbursed NF services long term, coordination with the MCO must occur. Similarly, when a CHOICES HCBS member admits to a NF for an MCO approved short term stay; a PAE application is not required. Additionally, any skilled and/or rehabilitative service needed during a short term stay is authorized by the MCO and does not require submission of a PAE application. In these instances, the NF must coordinate with the MCO. Typically, a short term stay can be approved for up to 90 Medicaid reimbursed days. The 90 days does not include days reimbursed by another payer source (including Medicare) and does not include bed hold days. Keep in mind though that the 10 day bed hold limit is applied across the short-term and long term NF benefit, (i.e. 10 days per member per year).

11.0 GATHERING DOCUMENTATION TO SUPPORT THE PAE

All PAE submissions are required to have specific supportive documentation reflecting the deficits as identified on the PAE. This documentation will be reviewed by TennCare and compared to the PAE and functional deficits as listed when determining LOC. If supportive documentation is not attached to the PAE according to specifications, LOC may be denied.

Required attachments to a NF PAE submission:

- A recent History and Physical (completed within 365 days of the PAE Request Date) AND/OR other recent medical records from a Physician, MD or DO (PA, APN, or NP) who provided the medical diagnoses which support the applicant's functional and/or skilled nursing or rehabilitative needs;
- Nursing Facility PAE Certification Form that satisfies the MD certification of medical necessity
- Certification of the accuracy of the PAE shall be required for all PAEs on the certification tab in The PAE Tracking System; and
- Supporting documentation for reimbursement of skilled nursing and/or rehabilitative services based on the need for such services.

Reminder: the PASRR process must be completed before a NF LOC determination can be made for Group 1 requests. A level I PASRR screen must be submitted via the Ascend web based system for all persons being admitted to a Medicaid certified NF regardless of payer source and regardless of disability. If the applicant has a suspected or diagnosed serious mental illness, intellectual disability or developmental disability the PASRR level I screen may be referred for a comprehensive level II evaluation. If referred for a Level II, a LOC screen will be required and may replace the need for a PAE submission via The PAE Tracking System.

Required attachments to a Safety Determination Request (in addition to PAE documents):

- Safety Determination Request Form
- Comprehensive needs assessment
- Person centered Plan of Care (except for AAAD submissions)
- Explanation regarding why an array of covered services and supports, including CHOICES HCBS up to the Expenditure Cap of \$15,000 and non- CHOICES HCBS (e.g., home health), services available through Medicare, private insurance or other

funding sources, and unpaid supports provided by family members and other caregivers would not be sufficient to safely meet the Applicant's needs in the community

- Any other documentation that may serve as evidence to support that a person's needs can't be safely met if enrolled in CHOICES Group 3.

Documentation must support each functional and/or skilled nursing or rehabilitative need specifically as these are approved/denied separately upon adjudication. For example, if someone is deficient in Transfer and Mobility and Communication as marked on the PAE, but the supportive documentation only shows why the person cannot transfer or ambulate (and does not show any issues related to communicating) then the Communication portion of the PAE may be denied. Again, this may affect the submitted acuity score as the Communication weighted value would result in a zero if it was completely denied or drop to a score lower than submitted if partially approved.

Documents submitted as supportive documentation must include the following to be considered valid documentation:

- Date (within the last 365 days)
- Identifying notation to indicate where the documentation originated (e.g., letterhead)
- Diagnoses
- Credentials of the document author

Acceptable and recommended documentation

- Current History and physical from applicant's physician or from a recent hospital stay
- Current ADL flow sheets
- Current Nurse's notes
- Section "G" of most recent MDS
- PT/OT assessments and notes
- Current physician, MD or DO, PA, APN, or NP progress notes
- Medical records from health departments
- Medical records from clinics
- Medical records from nursing facilities
- Recent physician office visits
- HCBS documentation tools

It is critical that qualified persons submitting a PAE complete the PAE in its entirety, being careful to accurately assess each functional area and to submit sufficient medical evidence to

support the assessed level of function, and that assessors are thorough in their review of the assessment and supporting documentation prior to certifying its accuracy. It is equally as important if requesting a safety determination that all required documents be submitted and that the supporting documents attached reflect and support the indicated safety concern(s).

12.0 SUBMITTING THE PAE

Now that you have reviewed program enrollment and eligibility criteria and performed the necessary assessments of the individual's need for assistance, it is time to apply for LOC or medical eligibility, for CHOICES. (Keep in mind, financial eligibility is a separate process and determination and requires a distinct application available on the TennCare website). PAE applications are submitted via a web based application known as The PAE Tracking System. To learn more about The PAE Tracking System and the correct submission of a PAE application, please visit TennCare's website.

Who can submit a PAE?

For TennCare to determine if a person can be authorized to submit a PAE via The PAE Tracking System the following must be performed as part of The PAE Tracking System user application process:

1. Complete the online PAE Tracking System training
2. Complete and submit a PAE Tracking System access form
3. Sign the Acceptable Use Policy (AUP)

Once these steps have been successfully completed, the user may request through TennCare, access to The PAE Tracking System. This is done by submitting the completed items above via email to LTC.Operations@tn.gov. TennCare works with its Information Security team to grant The PAE Tracking System access. Please contact LTC.Operations@tn.gov with questions about The PAE Tracking System access.

When should a PAE be submitted?

When a TennCare eligible person is admitted to a NF for receipt of TennCare reimbursed NF Services

1. When a private-paying resident of a NF attains TennCare eligible status
2. When a NF eligible person requires continuation of the same LOC beyond a PAE expiration date assigned by TennCare
3. When a person is applying for CHOICES or PACE
4. To determine an individual's cost neutrality cap for CHOICES Group 2

When a PAE must be submitted ?

Anytime there is a change in LOC such as:

1. When Medicare reimbursement for SNF services has ended and TennCare Level 2 reimbursement for NF services is requested
2. When a NF eligible person has a change in LOC such as a change from TennCare Level 1 to TennCare Level 2 reimbursement, or from TennCare Level 1 or Level 2 reimbursement to a Chronic Ventilator or Tracheal Suctioning Enhanced Respiratory Care rate, Enhanced Respiratory Care rate to TennCare Level 1 reimbursement, unless the person already has an approved unexpired Level 1 PAE
3. When a NF eligible person is changed from an Enhanced Respiratory Care rate to TennCare Level 2 reimbursement, unless the person has an approved unexpired Level 2 PAE
4. When a NF eligible person no longer requires the specific skilled nursing or rehabilitative services for which a Level 2 PAE was approved but requires other skilled nursing or rehabilitative services for which Level 2 reimbursement may be authorized in a NF
5. When a member enrolled in CHOICES Group 1 or Group 2 no longer meets NF LOC (in place at time of enrollment)
6. When a Member enrolled in CHOICES Group 3 no longer meets at risk LOC. When a Member enrolled in CHOICES Group 3 can no longer be safely served in CHOICES Group 3.

When a PAE is not required

1. When a NF Eligible with an approved unexpired Level 1 PAE returns to the NF after being hospitalized
2. When a NF Eligible with an approved unexpired Level 2 PAE returns to the NF after being hospitalized, if there has been no change in the skilled nursing or rehabilitative service for which the PAE was approved
3. When a NF Eligible changes from Level 2 to Level 1 NF reimbursement and has an approved unexpired Level 1 PAE
4. To receive Medicaid co-payment when Medicare is the primary payer of SNF care
5. When a Discharge/Transfer/Hospice Form is appropriate.
6. For authorization by an MCO of Ventilator Weaning services or short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention. Medical necessity determinations and authorization of Ventilator Weaning services and short-term payment at the Tracheal Suctioning Enhanced Respiratory Care rate during the post-weaning period will be managed by the person's MCO
7. When a person will be receiving hospice services in the NF.

12.1 The PAE TRACKING SYSTEM TECHNICAL REQUIREMENTS FOR PAE SUBMISSION

Once a PAE application is submitted to TennCare, the Division of Long Term Services and Supports PAE approval effective date determines whether all technical requirements for submission are met. The submission becomes a critical part of that individual applicant's permanent TennCare record. Therefore, it is imperative that the PAE application is complete and accurate. This section explores all of the information you are required to submit to TennCare. This includes information about the applicant; about you, as the submitter; about the provider of services; and, the purpose for requesting a LOC determination. Because accurate information is crucial at the onset of this process, TennCare conducts an initial screening of information referred to as technical verification and validation. Typically, technical reviews occur within 2 business days of PAE submission. When a PAE does not meet technical requirements, it is not sent to a TennCare nurse to determine if other criteria (including LOC) are met. The process ends with a notification to the submitter which is available in The PAE Tracking System. It lists the reason for the technical denial and remedy options. Typically, the submitter should immediately **REVISE** the PAE to remedy the deficiency noted and resubmit the PAE application. If all technical requirements are met, the PAE is forwarded to a TennCare nurse to determine if LOC criteria are met.

After the PAE has been submitted, if you believe that a technical error occurred, please submit a support ticket through The PAE Tracking System. To view how to complete a support ticket please visit TennCare's website to view LTSS' online training.

12.2 ENTERING IDENTIFYING INFORMATION IN THE PAE TRACKING SYSTEM

Applicant Information

All required fields must be completed for the applicant as follows:

Name-Bing, Chandler M.
Street Address-495 Grove Street
City, State ZIP-Central Perk, TN 33377
DOB-mm/22/yyyy
SSN-xxx-xx-xxxx
Medicaid Number if applicable
Telephone Number-444-555-6666

Designee Information

The designee is someone that the applicant MUST identify as the person that he/she wants to participate in decision making and receive information regarding the PAE. If the applicant chooses to not have someone else receive information regarding the PAE, he/she must sign the PAE to acknowledge and certify there is no designated correspondent. The PAE submitter must also acknowledge in The PAE Tracking System when there is no designee or the PAE may be technically denied. Identification of a designee is a court ordered requirement that ensures that appropriate parties acting on behalf of a PAE applicant are included in notifications of PAE decisions.

All required fields must be completed for the designee as follows:

Name-Bing, Chandler M.
Street Address-495 Grove Street
City, State ZIP-Central Perk, TN 33377
Telephone Number-444-555-6666

Submitting Entity Information

Auto-populates in The PAE Tracking System

Provider Information

Auto-populates in The PAE Tracking System

12.3 ENTERING ADDITIONAL INFORMATION IN THE PAE TRACKING SYSTEM

Along with identifying information, additional information is needed to help TennCare determine what services are being requesting. While the PAE application is submitted to determine LOC or medical eligibility for LTSS programs, it is also used to approve a higher reimbursement amount for level 2 services or enhanced respiratory care. It is used to alert TennCare when a current member has a change in LOC or has an end dated PAE but still meets LOC criteria. On all CHOICES PAEs, we need the submitter to tell TennCare why the PAE is being submitted so that we can ensure processes and decisions are accurate. This section details the additional information needed for CHOICES PAE submissions.

Service Requested

Check the box identifying the appropriate service that the applicant requests. If the applicant is choosing to remain in the home & community setting, choose "HCBS". If the applicant is choosing to admit into a nursing facility, choose "Nursing Facility".

HCBS Choices

- Check the box identifying the appropriate Target Group of the applicant:
 - If age 65 or older, choose "Age 65+"
 - If age 21 or older, choose "Physically disabled (21+)" and list the specific diagnosis or condition relating to the physical disability.
*In order to be approved for target population in Group 3, you must also submit supporting documentation related to the listed diagnosis or condition that meets the definition of physical disability in TennCare Rule.
- Check the box identifying the appropriate Cost Neutrality Cap to the applicant's service needs:
 - Level 1: would qualify for Level 1 NF care
 - Level 2: would qualify for Level 2 (or skilled) SNF care
 - CV (Chronic Ventilator): would qualify for enhanced respiratory care (i.e., for persons who are chronically ventilator dependent).
 - TS (Tracheal Suctioning) Secretion Management: would qualify for enhanced respiratory care (i.e., for persons who have a functioning tracheotomy that requires frequent suctioning through the tracheotomy as described above in Enhanced Respiratory Care).
- Check the box identifying the appropriate Submission Request Type for the PAE:
 - New CHOICES applicant: a person who is currently not a CHOICES member
 - Change in current LOC: a person who is a current CHOICES member and his/her level of care needs have changed in any manner such that it is not reflected on the current PAE
 - Current CHOICES member, current PAE ending: a person who is a current CHOICES member and his/her PAE is soon to end and the requestor believes CHOICES should continue
 - CN Cap determination: a current Group 2 CHOICES member whose needs have changed and therefore requires a change in the individual cost neutrality cap that is applied

Nursing Facility Choices

- Check the box identifying the appropriate Reimbursement Levels to the applicant's service needs:
 - Level 1: would qualify for Level 1 NF care
 - Level 2: would qualify for Level 2 (or skilled) SNF care
 - CV (Chronic Ventilator): would qualify for enhanced respiratory care (i.e., for persons who are chronically ventilator dependent).
 - TS (Tracheal Suctioning) Secretion Management: would qualify for enhanced respiratory care (i.e., for persons who have a functioning tracheotomy that requires frequent suctioning through the tracheotomy as described above in Enhanced Respiratory Care).
- Check the box identifying the appropriate Submission Request Type for the PAE:
 - New CHOICES applicant: a person who is currently not a CHOICES member
 - Change in current LOC: a person who is a current CHOICES member and his/her level of care needs have changed in any manner such that it is not reflected on the current PAE
 - Current CHOICES member, current PAE ending: a person who is a current CHOICES member and his/her PAE is soon to end and the requestor believes CHOICES should continue
 - Hospice: Hospice services are not Long Term Services or supports and do not require a PAE. If the service type being requested is hospice, please stop and do NOT submit the PAE.

Applicant Admitted From

If the applicant has been admitted into a nursing facility, check the box identifying the location that the applicant resided prior to admission; another nursing facility, home, hospice care, or hospital.

Applicant currently resides in a NF?

Answer the question Yes or No. If yes, document the date of admission to that facility. If available, document the facility Medicaid Provider number.

Discharge Expectation

Check the box identifying if the applicant is expected to discharge from the facility within the next six (6) months or not expected to discharge. This indication may affect decisions related to estate recovery and PAE approval effective dates.

Diagnosis

Enter the full diagnosis that is relevant to the applicant's functional and/or skilled nursing needs. This diagnosis should also be found within the supporting documentation that is attached to the PAE.

Entering the PAE Request Date

This is the date you want the PAE to be effective. As part of the PAE approval process, TennCare will determine the PAE approval effective date and will use what you enter as part of their decision. Please see Chapter 15.10 to learn more about how TennCare determines a PAE approval effective date.

Nursing Facility, Address/Phone Number(s)

Enter the full name of the nursing facility that the applicant is requesting for admission or a current resident of. Enter the facility's phone number including area code. Enter the full address of the facility including City, State, County and Zip Code.

Current NF payer source

Check the box identifying the current nursing facility payer source at the time of the PAE; Medicare or Private Pay (if other, please note).

Medicaid Only Payer Date

Enter the requested date of Medicaid payment for NF services (known as the **Medicaid Only Payer Date** or MOPD) if known at the time of the PAE submission. If the MOPD is unknown, the PAE will be processed and level of care determined. However, an MOPD is required before CHOICES enrollment can be approved. It is very common for facilities to submit a PAE then enter the MOPD at a later time once it is known. The PAE Tracking System home page includes a list of items waiting for an MOPD to be entered.

- The Medicaid Only Payer Date or MOPD is required before a person is enrolled into CHOICES Group 1 (care in a Nursing Facility or NF).
- In addition to other CHOICES enrollment requirements, the Bureau of TennCare must have received notification from the NF that Medicaid reimbursement is being requested for the effective date of CHOICES enrollment. This requirement is cited in [TennCare Rule 1200-13-01-.02](#).
- The MOPD is the date the NF intends to bill the MCO (CHOICES) for NF services because no other payer source exists. Other payers include third party liability

such as private insurance or Medicare. It also means that the patient is not privately paying.

The MOPD is a known date; it's not a guess or an estimate. This means that the MOPD should not change once entered into The PAE Tracking System. If a MOPD does change, the MCO must be contacted. Sometimes the MOPD is known at the time the PAE is submitted. Sometimes the MOPD is not known until more information is gathered about other payer sources. A NF can enter the MOPD at any time; there is no time limit. However, if there is more than 90 days between the PAE approved effective date and the Medicaid Only Payer Date a facility has to recertify the PAE. If there is more than 365 days between the PAE approved effective date and the Medicaid Only Payer Date a facility has to submit a new PAE.

Here are some examples:

1. NF submits a PAE that is approved on 7/1/12. On 12/1/12, the NF enters the MOPD. The MOPD is 8/1/12. In this case, the NF does NOT have to recertify the PAE.
2. NF submits a PAE that is approved on 7/1/12. On 6/1/13, the NF enters the MOPD. The MOPD is 12/1/13. In this case, the NF does have to recertify the PAE.
3. NF submits a PAE that is approved on 7/1/12. On 8/1/13, the NF enters the MOPD. The MOPD is 8/1/13. In this case, the NF has to submit a new PAE.

12.4 COMPLETING THE FUNCTIONAL ASSESSMENT TAB IN THE PAE TRACKING SYSTEM (not included in other sections)

In Chapter 10 we detailed performing and finalizing the functional assessment, ensuring that each area is complete. When you have completed your assessment, you should have a very good idea of how the individual will score on the functional assessment. Mark the responses on the PAE which reflect the functional abilities as you observed and as reflected in the documentation. Rely on your skilled clinical knowledge, effective observation and assessment skills and the preponderance of the documentation to assist you in completing the PAE. Upload and attach all of the documents to the PAE prior to submitting to TennCare. Please label each attachment clearly.

12.5 COMPLETING THE SKILLED NURSING AND REHABILITATIVE SERVICES TAB IN THE PAE TRACKING SYSTEM (not included in other sections)

For any applicant who requires one or more of the specified skilled nursing and/or rehabilitative services as described in Chapter 10, check the box identifying ONLY those services that apply to the specific applicant, if any. Do not mark this page if there are no services that apply to the applicant. Upload and attach all of the required and supporting documents to the PAE prior to submitting to TennCare. Please label each attachment clearly.

12.6 COMPLETING THE SAFETY TAB IN THE PAE TRACKING SYSTEM (not included in other sections)

If you are requesting a safety determination you will indicate which area(s) triggered the need for the safety determination request and make sure to upload all required and supporting documents. Please make sure to label each attached document clearly. For required documents, label them as instructed on the Safety Determination Request Form.

12.7 FINALIZING AND SUBMITTING THE PAE (not included in other sections)

Once you have completed the PAE including the functional assessment, uploaded and attached all required and supporting documentation, and completed all certifications as appropriate, you are ready to submit your PAE. Before you hit the “submit” button ask yourself these questions:

- Are all demographics complete and accurate?
- Are all of the responses on the functional assessment complete, true and accurate?
- Does the documentation I submitted support the responses as marked on the functional assessment?
- Did I request a safety determination; if so, are all of the responses on the safety determination complete, true and accurate?
- Have I supplied all of the required attachments?
- Have I met all of the technical requirements of a PAE submission?

If the answer to all of these questions is “yes”, then you should submit your PAE. You can do this by hitting the “SUBMIT” button in The PAE Tracking System. You will then get a message indicating that your PAE has been submitted. Each PAE is assigned a control number.

12.8 Additional MCO and AAAD Documentation Requirements

For all PAEs submitted by the MCO, the *MCO Checklist* must be uploaded as an attachment to the PAE. This form is required to make an accurate financial eligibility decision, but is not required for PAE adjudication.

For all PAEs submitted by the AAAD, a completed Sams ILA (NSI) 2007 Assessment, and Freedom of Choice form must be uploaded as an attachment to the PAE. This information is used to relay information to the appropriate MCO in the event the PAE is approved and the applicant is subsequently enrolled in CHOICES but is not required for PAE adjudication.

13.0 TENNCARE PAE DETERMINATION

Once you have completed and submitted the PAE via the PAE Tracking System, TennCare verifies that the submission is valid as detailed in Chapter 9. Once a PAE application is determined to be technically correct and not a duplicate PAE, the PAE application is forwarded to a TennCare Registered Nurse (RN). This section outlines all of the decisions the TennCare PAE nurse makes when determining LOC.

In order to meet NF LOC requirements, TennCare must determine that an applicant meets both of the following criteria:

1. Medical Necessity of Care
2. Need for inpatient Nursing Care
 - a. Have a total acuity score of at least 9; or
 - b. Meet At Risk criteria on an ongoing basis and be determined by TennCare to not qualify for enrollment into group 3 based on a Safety Determination.

In order to meet “At Risk” LOC requirements TennCare must determine that an applicant meets both of the following criteria:

1. Medical Necessity of Care
2. Need for inpatient Nursing Care
 - a. Have a significant deficit (needs assistance daily or at least 4 days per week) in an ADL or ADL Related function as indicated and approved on the PAE application.

In addition to LOC determinations, TennCare determines the following:

1. Level of NF reimbursement based on skilled nursing and rehabilitative services needed.
2. Whether there is an appropriate PASRR or a need for referral (for CHOICES Group 1 only).
3. Individual cost neutrality caps for people applying for or enrolled in CHOICES Group 2
4. PAE approval effective and end dates.
5. Validity of Qualified Assessor certification.

This Chapter explains these decisions in more detail.

13.1 DETERMINING MEDICAL NECESSITY OF CARE

For persons requesting care in a Nursing Facility:

To meet this provision of LOC, care in a nursing facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis. (Group 1)

These criteria are satisfied through Physician (or PA, NP, APN as applicable) signature on the PAE certification form (attachment C). This signature serves as an attestation that the applicant requires the level of care provided in a nursing facility and that the requested long-term care services are medically necessary as defined above. The signer further attests that such care is ordered and supervised by a physician on an ongoing basis.

Any intentional act to provide false information that would potentially result in a person obtaining benefits or coverage to which he/she is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. Additionally, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.

It is important that the most recently updated form is used and attached to any NF or PACE PAE requesting NF services. The most recently updated form is always available on the TennCare website and can also be found and printed from the submitter homepage in the PAE Tracking System. The PAE certification form must be completed in its entirety and must include an original signature and the date LOC is certified as medically necessary. PAEs requesting NF services without this information will be denied NF LOC as not meeting the Medical Necessity of Care requirement.

For persons requesting HCBS in CHOICES or PACE:

To meet this provision of LOC, HCBS must be required in order to allow the person to continue living safely in the home or community-based setting and to prevent or delay placement in a nursing facility, and such HCBS must be specified in an approved plan of care and needed *on an ongoing basis*. The need for *one-time* HCBS is not sufficient to meet medical necessity of care for HCBS.

If a person's ongoing need for assistance with activities of daily living and/or instrumental activities of daily living can be met through the provision of assistance by family members and/or other caregivers, or through the receipt of services available to the member through community resources (e.g., Meals on Wheels) or other payer sources (e.g., Medicare), he/she does not require HCBS in order to continue living safely in the home and community-based setting and to prevent or delay placement in a nursing facility.

This criterion is satisfied by MCOs through the completion of the cost neutrality tab in the PAE Tracking System by listing the services and frequency. It is satisfied by the AAADs with a checkbox in the PAE Tracking System indicating the need for ongoing HCBS. PACE satisfies this requirement through physician certification. PAEs requesting HCBS without this information will be denied NF LOC as not meeting the Medical Necessity of Care requirement.

13.2 DETERMINING THE NEED FOR INPATIENT CARE

For persons requesting care in a Nursing Facility: (included in group 1)

The individual must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The individual must be unable to self-perform needed nursing care and must:

- Have a total acuity score of at least 9 on the TennCare NF LOC Acuity Scale; or
- Meet "At Risk LOC" criteria on an ongoing basis and be determined by TennCare to not qualify for enrollment into group 3 based on a Safety Determination.

For persons eligible to receive care in a NF, but requesting HCBS in CHOICES or PACE:

The applicant has a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. In the absence of such HCBS the person would require and must qualify to receive NF services in order to remain eligible for HCBS. The individual must be unable to self-perform needed assistance and must:

- Have a total acuity score of at least 9 on the TennCare NF LOC Acuity Scale; or
- Meet At Risk LOC criteria on an ongoing basis and be determined by TennCare to not qualify for enrollment into group 3 based on a Safety Determination.

This criterion is satisfied in part by the diagnosis listed on the PAE (For NF requests, the certification form which includes certification of the diagnosis via signature by the Physician, PA, APN, or NP as applicable). The diagnosis must also be supported by medical evidence. The PAE nurse also reviews the functional assessment and supporting medical documentation to

determine the total acuity score. The following chart represents each functional measure and associated values:

LEVEL OF CARE ACUITY SCALE TOOL

Functional Measure	Condition	Always	Usually	Usually not	Never	Maximum Individual Acuity Score	Maximum Acuity Score for the Measure(s)
Transfer	Highest value of two measures	0	1	3	4	4	4
Mobility		0	1	2	3	3	
Eating		0	1	3	4	4	4
Toileting	Highest value of three questions for the toileting measure	0	0	1	2	2	3
Incontinence care		0	1	2	3	3	
Catheter/ostomy care		0	1	2	3	3	
Orientation		0	1	3	4	4	4
Expressive communication	Highest value of two questions for the communication measure	0	0	0	1	1	1
Receptive communication		0	0	0	1	1	
Self-administration of medication	First question only; excludes Sliding Scale insulin	0	0	1	2	2	2
Behavior		3	2	1	0	3	3
Maximum possible ADL (or related) Total Acuity Score							21

Also included in the total acuity score are any values assigned to the approval of skilled and/or rehabilitative needs as documented on the PAE application and supported by medical evidence. Section 3 of this chapter discusses determinations related to skilled and rehabilitative services

in more detail. The following chart represents the skilled and rehabilitative services captured on the PAE application and the associated values:

SKILLED OR REHABILITATIVE SERVICE VALUES

Skilled or rehabilitative service	Maximum Individual Acuity Score
Ventilator	5
Frequent tracheal suctioning	4
New tracheostomy or old tracheostomy requiring suctioning through the tracheostomy multiple times per day at less frequent intervals, i.e., < every 4 hours	3
Total Parenteral Nutrition (TPN)	3
Complex wound care (i.e., infected or dehisced wounds)	3
Wound care for stage 3 or 4 decubitus	2
Peritoneal dialysis	2
Tube feeding, enteral	2
Intravenous fluid administration	1
Injections, sliding scale insulin	1
Injections, other IV, IM	1
Isolation precautions	1
PCA pump	1
Occupational Therapy by OT or OT assistant	1
Physical Therapy by PT or PT assistant	1
Teaching catheter/ostomy care	0
Teaching self-injection	0
Other	0
Maximum Possible Skilled Services Total Acuity Score	5

Modified Approval

A TennCare PAE nurse may approve a modified score for an ADL or related deficiency based on information provided in the supporting medical documentation. TennCare does not simply approve or deny the submitted score for each ADL deficiency. Instead, TennCare may approve a modified score when supported by medical evidence, while preserving the integrity of the originally filed application. These modifications are not intended to replace the vital service provided by PAE assessors. It is critical that NFs and other submitting entities make every effort to ensure that the assessment information submitted in the PAE accurately reflects the applicant’s level of functioning, and that medical evidence submitted is consistent with and supports the functional deficits identified in the application. Remember that an assessor is certifying that the information provided in the PAE assessment is accurate and is accountable for accurate submissions.

For persons not eligible to receive care in a NF, but “at risk” of NF placement and requesting HCBS in CHOICES

The applicant has a physical or mental condition, disability, or impairment that requires ongoing supervision and/or assistance with activities of daily living in the home or community setting. In the absence of such HCBS, the person would not be able to live safely in the community and would be at risk of NF placement. The applicant must require supervision and/or assistance daily or at least 4 times per week with one or more activities of daily living (as listed on the PAE application) on an ongoing basis.

These criteria are satisfied in part by the diagnosis listed on the PAE in the PAE Tracking System and as supported by medical evidence. The PAE nurse also reviews the functional assessment and supporting medical documentation to determine if at least one significant deficit exists. A significant deficit is a deficit in an ADL or related function as listed on the PAE application that requires assistance daily or at least 4 times weekly. An acuity score is not used to determine if a person meets “At Risk” LOC. The following chart shows each functional measure and the associated significant deficit:

SIGNIFICANT DEFICITS

Functional Measure	Always	Usually	Usually not	Never
Transfer			*	*
Mobility			*	*
Eating			*	*
Toileting			*	*
Incontinence care			*	*

Catheter/ ostomy care			*	*
Orientation			*	*
Expressive communication			*	*
Receptive communication			*	*
Self- administration of medication			*	*
Behavior	*	*		

A TennCare determination that an applicant does not qualify to enroll in CHOICES Group 3

Once a person is determined to *not* have a score of at least 9 on the TennCare Acuity Scale (attached), the PAE nurse determines if the person meets At Risk LOC. If a person does not meet NF LOC requirements but does meet At Risk LOC requirements, TennCare must determine if enrollment criteria for CHOICES Group 3 is met. This decision includes a determination that:

- a) The applicant is in the defined **target population** for CHOICES HCBS (age 65 or older or age 21 or older with physical disabilities);

TennCare makes this determination using all the information that is provided with the PAE application.

The decision also includes a determination that:

- b) The applicant’s needs can be safely and appropriately met in the community with the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3:
 - including CHOICES HCBS up to the expenditure cap of \$15,000
 - non-CHOICES HCBS available through TennCare (e.g., home health), services available through Medicare, private insurance or other funding sources, and
 - unpaid supports provided by family members and other caregivers.

TennCare makes this determination only when a complete safety determination request is received. Individuals who meet At Risk LOC requirements who cannot be safely served if enrolled in CHOICES Group 3 will be granted NF LOC approval and as long as all other

enrollment and eligibility requirements are met, will be approved for TennCare reimbursed NF services through CHOICES Group 1 or for more comprehensive HCBS through CHOICES Group 2 or PACE.

13.3 DETERMINING THE INDIVIDUAL ACUITY SCORE

TennCare has assigned a weighted value to each of the possible responses to each question on the PAE, based on the amount of assistance that would be required for a person with that type and level of ADL or related deficit. Each response must be supported by the medical evidence submitted with the PAE. An **individual acuity score** is the weighted value assigned to:

- 1) The response to a specific ADL (or related) question on the TennCare PAE that is supported by the medical evidence submitted with the PAE; or
- 2) A specific skilled or rehabilitative service determined by TennCare to be needed by the applicant based on the medical evidence submitted with the PAE.

How an individual acuity score is calculated:

Submitted answers on the functional assessment are reviewed by a TennCare nurse and may be approved, denied or partially approved based on a review of all the submitted supporting documentation. Only those answers to functional measures approved or partially approved by TennCare will apply to the approved acuity score. This means the acuity scores populated by the PAE Tracking System at the time of submission, the PAE Tracking System user can anticipate TennCare's LOC decision, but scores are not final until the PAE is reviewed and approved by TennCare.

- If an answer provided on the functional assessment is denied, the score assigned for that functional measure is 0.
- If it is approved as submitted, the ADL (or related) measure will receive the full weighted value for that measure.
- If a functional assessment answer is partially approved by TennCare because the supporting documentation does not support the answer given, but does support a lesser frequency of the deficit, the functional measure is awarded the value assigned with the response best supported by the documentation.

For example: A response of "Never" is submitted for the functional measure of transfer. Upon submission of the PAE, the PAE Tracking System provides the user with a "submitted" score of 4 for that deficit. TennCare reviews the documentation and finds that it does not support that the applicant can "never" transfer without assistance. It does however, support that the applicant needs assistance with transferring most days of the week (4). In this case, the TennCare nurse denied the response of "never" but

assigns the value provided for a response of “usually not”, giving the functional measure an “approved” score of 3.

Specific areas on the functional assessment are captured based on condition and assigned weighted values based on such. These conditions are as follows:

1. Maximum Acuity Score for Transfer and Mobility

Assessment of the need for assistance with transfer and the need for assistance with mobility are separate but overlapping measures of an applicant’s physical independence (or dependence) with movement.

The maximum individual acuity score for transfer is 4.

The maximum individual acuity score for mobility is 3.

The highest individual acuity score among the transfer and mobility measures is the applicant’s total acuity score across both measures.

The maximum acuity score across both the transfer and mobility measures is 4.

2. Maximum Acuity Score for Toileting

Assessment of the need for assistance with toileting includes the following:

- a) An assessment of the applicant’s need for assistance with toileting;
- b) Whether the applicant is incontinent, and if so, the degree to which the applicant is independent in incontinence care; and
- c) Whether the applicant requires a catheter and/or ostomy and if so, the degree to which the applicant is independent with catheter and/or ostomy care.

The highest individual acuity score among each of the 3 toileting questions is the applicant’s total acuity score for the toileting measure.

The maximum acuity score for toileting is 3.

3. Maximum Acuity Score for Communication

Assessment of the applicant’s level of independence (or deficit) with communication shall include an assessment of expressive as well as receptive communication.

The highest individual acuity score across each of the 2 communication questions is the applicant’s total score for the communication measure.

The maximum possible acuity score for communication is 1.

4. Maximum Acuity Score for Self-Administration of Medication

Assessment of the applicant's level of independence (or deficit) with self-administration of medications as an ADL-related function shall not take into consideration whether the applicant requires sliding scale insulin and the applicant's level of independence in self-administering sliding scale insulin.

Sliding scale insulin is considered along with other skilled and/or rehabilitative services for which TennCare could authorize level 2 NF reimbursement.

The maximum individual acuity score for self-administration of medication is 2.

The maximum individual acuity score for sliding scale insulin is 1.

The maximum possible acuity score for ADLs or related deficits is 21.

Skilled Nursing and/or Rehabilitative Services

TennCare has also assigned a weighted value to each of the skilled and/or rehabilitative services for which level 2 or enhanced respiratory care NF reimbursement could be authorized, when determined by TennCare to be needed by the applicant on a daily basis or at least five days per week for rehabilitative services, based on the medical evidence submitted with the PAE.

For any applicant who requires one or more of the specified skilled nursing or rehabilitative services and at a frequency (daily for each of the specified skilled services and at least five (5) days per week for each of the specified rehabilitative services) for which level 2 NF reimbursement may be approved by TennCare, the submitter completes the applicable portions of the PAE and includes documentation required for determination of eligibility for level 2 or enhanced respiratory care NF reimbursement (as applicable), regardless of whether the applicant's care will be provided in a NF or in the community. A Physician's Order is not required if the skilled or rehabilitative services are being performed by a family member under a specified exemption to the Nurse Practice Act. However, the PAE must include medical records sufficient to document the need for each skilled or rehabilitative service(s), including the frequency of each service, as would be required for determination of eligibility of a higher level of NF reimbursement. This information will be used for purposes of determining the applicant's total acuity score (regardless of setting), as well as the applicant's cost neutrality cap if enrolled in CHOICES Group 2.

The highest individual acuity score across all of the skilled and/or rehabilitative services is used to calculate the applicant's acuity total for skilled and/or rehabilitative services.

The maximum possible acuity score for skilled and/or rehabilitative services is 5.

13.4 DETERMINING THE TOTAL ACUITY SCORE

The applicant's approved acuity total for each functional measure (or in the case of transfer and mobility, across both measures) will be added to determine the applicant's total ADL and related deficit acuity total up to a maximum of 21. The applicant's total ADL and related deficit acuity total will be added to the applicant's skilled and rehabilitative services acuity total (up to a maximum of 5) to determine the applicant's approved total acuity score. The maximum total acuity score is 26.

PRACTICAL EXAMPLES

Example A:

Based on responses to questions in the PAE functional assessment and supported by medical evidence submitted with the PAE, Applicant A is "Never" independent with transfer, mobility, eating or toileting, but is continent and does not have a catheter or ostomy. In addition, Applicant A is "Never" independent in administration of medication, despite the provision of assistance as specified in the PAE. Applicant A is "Always" oriented to person and place and "Always" independent in expressive and receptive communication. Applicant a "Never" requires intervention for dementia-related behaviors. Applicant A does not require any of the specified skilled or rehabilitative services for which Level 2 NF reimbursement would be authorized.

- The acuity score for the transfer measure is 4.
- The acuity score for the mobility measure is 3.
- The combined acuity score across the transfer and mobility measures is 4 (the highest value across the two measures).
- The acuity score for the eating measure is 4.
- The acuity score for the first toileting question is 2.
- The acuity scores for the incontinence and catheter/ostomy care questions are each 0.
- The acuity score for the toileting measure is 2 (the highest value of three possible questions for the toileting measure).
- The acuity score for the orientation measure is 0.
- The acuity score for expressive communication is 0.
- The acuity score for receptive communication is 0.
- The acuity score for the communication measure is 0 (the highest value of two possible questions for the communication measure).
- The acuity score for the self-administration of medication measure is 2.
- The acuity score for the behavior measure is 0.

- The total ADL or related acuity score is 12.
- The skilled services acuity score is 0.
- The applicant's **total acuity score** is 12.

Example B:

Based on responses to questions in the PAE functional assessment and supported by medical evidence submitted with the PAE, Applicant B is “Always” independent with transfer, mobility, eating and all aspects of toileting; “Never” oriented to person and place; “Always” independent with expressive communication and “Usually” independent with receptive communication; “Never” independent with self-administration of medication, despite the provision of assistance as specified in the PAE (due to cognitive impairments); and “Always” requires intervention for persistent behaviors (not primarily related to a mental health condition or substance abuse disorder). Applicant B does not require any of the specified skilled or rehabilitative services for which Level 2 NF reimbursement would be authorized.

- The acuity score for the transfer measure is 0.
- The acuity score for the mobility measure is 0.
- The combined acuity score across the transfer and mobility measures is 0 (the highest value across the two measures).
- The acuity score for the eating measure is 0.
- The acuity score for each of the toileting questions is 0.
- The acuity score for the toileting measure is 0 (the highest value of three possible questions for the toileting measure).
- The acuity score for the orientation measure is 4.
- The acuity score for expressive communication is 0.
- The acuity score for receptive communication is 0.
- The acuity score for the communication measure is 0 (the highest value of two possible questions for the communication measure).
- The acuity score for the self-administration of medication measure is 2.
- The acuity score for the behavior measure is 3.
- The total ADL or related acuity score is 9.
- The skilled services acuity score is 0.
- The applicant's **total acuity score** is 9.

Now you should completely understand how the total acuity score is derived by TennCare and have specific examples showing exactly how it is calculated. When an applicant has a total acuity score 9 or above, this part of the “need for inpatient care” provision is met. When an applicant scores less than 9, another level of care determination is made. You should also fully understand how TennCare makes a decision regarding whether an applicant meets At Risk Level of Care.

Next, we will detail the TennCare safety determination portion of the PAE adjudication process. Remember, a safety determination is made when a person does not meet the “need for inpatient care” provision of NF LOC but does meet the “need for inpatient care” requirement for At Risk LOC approval **and** a completed safety determination request is received by TennCare.

13.5 MAKING A SAFETY DETERMINATION

A safety determination is a decision made by TennCare regarding whether an applicant would qualify to enroll in CHOICES Group 3 or if there is sufficient evidence, as required and determined by TennCare, to demonstrate that the necessary intervention and supervision needed by the applicant cannot be safely provided within the array of services and supports that would be available if the applicant was enrolled in Choices Group 3, including CHOICES HCBS up to the Expenditure Cap of \$15,000, non-Choices HCBS available through TennCare (e.g., home health), cost-effective alternative services (as applicable), services available through Medicare, private insurance or other funding sources, and natural supports provided by family members and other caregivers who are willing and able to provide such care, and which may impact the applicant’s NF LOC eligibility.

TennCare’s safety determination is based on a review of the medical evidence in its entirety, including consideration of the applicant’s medical and functional needs, and the array of services and supports that would be available if the Applicant was enrolled in CHOICES Group 3 as described above. The lack of availability of suitable community housing or the need for assistance with routine medication management shall not be sufficient by itself to justify approval of a safety determination request. Additionally, an applicant who could be safely served in CHOICES Group 3 except that he does not meet Medicaid categorical and financial eligibility criteria for CHOICES Group 3 (i.e. is not an SSI recipient) shall not be eligible for CHOICES Group 1 or Group 2 as a result of a Safety Determination.

Anytime a safety determination is requested and justification as indicated in Chapter 11 is provided and supported but the medical evidence received by TennCare is insufficient to make a Safety Determination, TennCare may request a face-to-face assessment by the AAAD (for non-Medicaid-eligible Applicants), or the MCO (for Medicaid-eligible Applicants), in order to gather additional information needed by TennCare to make a final safety determination. In such instances, the PAE shall be deemed incomplete, and the time for disposition of the PAE shall be tolled for a reasonable period of time (not to exceed 10 business days, except when such delay is based on the reasonable needs or request of the applicant, and only for a specific additional

period not to exceed a total period of more than 30 calendar days) while such additional evidence is gathered.

TennCare may also make a Safety Determination when none of the criteria specified in section 11.1 have been met, but a Safety Determination is requested based on other safety concerns and when the request includes sufficient supporting medical evidence.

A Safety Determination is approved if there is sufficient evidence to demonstrate that the necessary intervention and supervision needed by the applicant cannot be safely provided within the array of services and supports that would be available if the applicant was enrolled in CHOICES Group 3. When a safety determination request is approved, NF LOC is approved for the applicant. If subsequently enrolled in CHOICES Group 1 or 2 or in PACE based upon approval of a safety determination, the submitting entity requesting the safety determination request (NF, MCO, or PACE Organization) must implement any **Plan of Care (POC)** developed by that entity and submitted as part of the safety determination request and used to demonstrate the services needed by the applicant. This means that if the NF submits a PAE with a safety determination request and as part of that request, includes a POC which shows the services needed to safely serve the member in the NF and TennCare subsequently approves the PAE for NF LOC based on a safety determination, then the POC submitted as part of the request must be implemented.

Categorical Determinations (Group 1 chapter 5.5.2)

- Exempted Hospital Discharge (EHD) – a person is currently admitted to the hospital and is going to the NF for treatment of the condition for which s/he received hospital care, and whose physician certifies will likely require 30 days or fewer of NF services.
- Convalescent Care – a person is currently admitted to the hospital and is going to the NF for treatment of the condition for which s/he received hospital care, and whose physician certifies will likely require 60 days or fewer of NF services.
- Terminal Illness – a person has a terminal illness, and whose physician certifies s/he has a life expectancy of 6 months or less. This outcome provides 180 calendar days in the NF.
- Severe Physical Illness – a person who has a coma, ventilator dependence, functioning at brain stem level, or diagnoses, such as, Parkinson’s disease, Huntington’s disease, or ALS, which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services. This is not a time limited stay, although the person’s

physician must certify the individual's condition. A new Level I screen should be submitted should there be any improvement in the person's physical condition.

- Dementia and ID – a person has an intellectual disability and dementia and whose physician certifies the condition.
- Respite – a person who resides in a community setting and requires a brief NF admission to provide respite to in-home caregivers. Up to 9 days for CHOICES members.

AUTHORITY FOR FINAL DETERMINATIONS (g 1 chapter 5.5.3)

TennCare is contracted with both the Department of Mental Health (DMH) and the Department of Intellectual and Developmental Disabilities (DIDD) who, per federal regulations, have final authority over PASRR Level II determinations.

PASRR APPEALS (g 1 chapter 5.5.4)

During a PASRR LOC appeal, the appeals team will communicate with ASCEND, DMH and/or DIDD to schedule hearing, make changes to determination and assist with the hearing process.

PASRR CONDITION OR SUSPICION OF PASRR CONDITION (g 1 chapter 5.5.5)

In the event that an applicant develops a PASRR condition or suspicion of a PASRR condition after being admitted to the NF or has a significant change in their status which may result in a change in the plan of care or need for specialized services, regardless if they have previously been identified through PASRR, a change of status should be submitted by the NF via the ASCEND web system. If it determined by ASCEND that the applicant either has a PASRR condition i.e. serious mental illness, intellectual disability or developmental disability, or has suspicion of a PASRR condition, ASCEND will refer the positive Level I screen for a comprehensive Level II evaluation which will consist of a LOC evaluation. If the LOC is denied through the PASRR process a new PASRR and LOC may be submitted, or the submitter may contact ASCEND and request a reconsideration of the application.

13.6 DETERMINING PAE EFFECTIVE DATES

Determining PAE Approved Effective Dates:

If a PAE is approved (for NF LOC, or when NF LOC is denied, but At Risk LOC is approved), the effective date of the approved PAE may be the PAE request date as indicated by the submitter or, for NF PAEs approved for NF LOC, the physician certification date, whichever is earlier, keeping in mind the following:

- The effective date of NF LOC for an approved NF PAE can't be before the date of an appropriate PASRR.
- A PAE approval effective date may not be greater than ten (10) days prior to the date of PAE submission. When a PAE request date is more than 10 days before the date of submission, the PAE request date used by the PAE Reviewer to determine the PAE approval effective date is a date of 10 days prior to PAE submission.
- A Recertified PAE is approved using the PAE approval effective date of the original PAE, so long as the approval effective date on the recertified PAE does not exceed the end date of the original PAE.
- A revised PAE cannot have an approval date more than 10 days prior to the date all information which cured the original deficiency is submitted.
- If a Recertification is submitted within thirty (30) days of a retro-active financial eligibility determination, the effective date can go back as far as the original PAE approval effective date.

Determining PAE End Dates:

A PAE may be approved for a fixed period of time with an expiration date based on an assessment of the applicant's medical condition and anticipated continuing need for inpatient nursing care. PAE approval end dates are determined using clinical nursing judgment in conjunction with:

1. Medical documentation submitted which demonstrates that the condition of the applicant may improve over a period of time in such a degree that the applicant will no longer need the level of care approved;
2. Duration requested and/or approved for skilled nursing and/or rehabilitative services;
3. Duration of Physician Orders;
4. An indication by the PAE submitting entity of "within 6 months" in the discharge expected field in the PAE Tracking System (only for NF requests when NF LOC approved); and
5. A PASRR determination that NF is appropriate only on a short term basis (only for NF requests when NF LOC approved).

A safety determination may include NF LOC approval periods of less than 30 days when it is determined that additional post-acute inpatient treatment of no more than 30 days is needed for stabilization, rehabilitation, or intensive teaching as specified in the plan of care following an acute event, newly diagnosed complex medical condition, or significant progression of a previously diagnosed complex medical condition in order to facilitate the applicant's safe transition back to the community.

When a PAE is approved with an expiration date, the only way to extend PAE approval past the end date is to submit a new PAE. A recertified PAE cannot extend a PAE end date.

14.0 NOTIFICATION OF PAE STATUS AND DECISIONS

Users should always check The PAE Tracking System homepage to know which PAEs are pending submission, pending TennCare determination, requiring an MOPD (NF only), and which PAEs have been adjudicated by TennCare. When a PAE is determined by TennCare, the PAE control number will be available on the user's PAE Tracking System homepage. You can also search the PAE Tracking System by entering the control number.

TennCare LEVEL OF CARE DECISIONS

TennCare LOC decisions can be viewed in the PAE Tracking System by opening the PAE and reviewing the Request Information Tab. The current status will read "Approved" or Denied". If denied, the user should view the "Denial Override" field to know if the PAE was approved for At Risk LOC.

VIEWING ASCEND LEVEL OF CARE DECISIONS

When LOC is made by ASCEND, the admitting agency must enter the admission date into Path Tracker to view the LOC decision. The user may search the ASCEND website by Client Identification (CID) number, SSN or name. ASCEND LOC decisions can be viewed by opening the episode identification number. Further instruction may be found at <https://ASCENDami.com>, tools and resources by State; choose Tennessee from the dropdown for training and instructions.

VIEWING ENROLLMENT DECISIONS

In addition to LOC decisions, users can also view enrollment decisions. This includes whether enrollment into CHOICES or PACE is approved or denied. If approved, you will see the enrollment effective date. However, you should always rely on **TNAnytime** to confirm CHOICES enrollment information. Enrollment denial reasons will be included in the PAE Tracking System as well.

14.1 VIEWING THE DENIAL REASON IN THE PAE TRACKING SYSTEM

If LOC is indicated as denied on the Request Information Tab in the PAE Tracking System, there are three (3) places where you can get detailed information about the denial and reason(s).

First, the TennCare nurse indicates a decision (approved, denied or partially approved) next to each functional measure response you listed on the Functional Assessment Tab in the PAE Tracking System. For any measure denied or partially approved, line by line comments

regarding the denial of that deficit, including the specific inconsistencies or inadequacies in the medical evidence, are documented next to each functional measure response. This allows the submitter to clearly identify which functional deficits were not supported by the medical evidence such that additional information can be submitted as appropriate, or an appeal can be filed if a mistake was made in reviewing the information submitted.

There may also be on the request information page a denial reason explanation by the PAE nurse reviewer. Second, a denial reason explanation from the PAE nurse reviewer may be found on the request for information page.

Second, the denial reason can be reviewed on the formal notification of denial available in the PAE Tracking System and titled “Notice of Denial”.

A third place to review a denial reason is the formal notification of denial, which is available in the PAE tracking system, titled “Notice of Denials.” It is housed in the PAE Tracking System as a Related Item under “Generated Attachments”. This Notice of Denial is designed for submitters and specifies the reason for denial.

There are two (2) provider notification letters used by TennCare. One is the technical denial letter. The second is the Medical Necessity Denial letter.

14.2 TECHNICAL DENIALS

The technical denial notification is generated when technical requirements are not met to successfully submit the PAE for TennCare review and submitter action is required to correct an error. When a technical denial is issued, the submitter must immediately remedy the error in the PAE Tracking System and resubmit the PAE for determination. Technical denial notifications are very specific in identifying for the submitter the error made in submission and also how to remedy the error.

Reasons for a technical denial and actions step instructions as indicated on the technical denial provider notification include:

- Duplicate PAE: Applicant has an active PAE for the same level of care and date span as this request. If this is a change in level of care, please indicate such as the “submission request type”.
- Incorrect applicant information submitted: Please revise PAE with correct applicant information and submit.
- Incorrect provider information submitted: Please revise PAE with correct provider information and submit.

- Incorrect Designee information submitted: Please revise PAE with correct designee information and submit.
- Certification of Assessor not complete: Please revise PAE with complete information regarding the qualified assessor on the Certification Tab and submit.
- Recertification of this PAE is not necessary: MOPD is 90 days or less from approval effective date or applicant is already enrolled in CHOICES.
- Qualified Assessor (or code) listed does not match attached documentation: Please revise PAE and enter correct Qualified Assessor name or code in the PAE Tracking System.
- The PAE is end dated and a request is submitted to extend the end date: A new PAE is required.
- The PAE is greater than 30 days from date of denial or over 365 days old: A new PAE is required.

A skilled service extension is requested more than 5-8 business days from the previous end date or more than 10 days past the end date of the previous approval of the skilled or ERC service: If the request is greater than 10 days from the previous end date a new PAE is required.

14.3 DENIAL FOR MEDICAL NECESSITY

Common reasons for medical necessity denials Include:

1. The signed certification page is missing from the submission
2. No medical documentation is submitted
3. For re-certifications when the certifier of LOC signature and date are missing
4. No orders for NF submitted.
5. For AAAD HCBS submissions when the ongoing services box is not checked
6. For MCO HCBS submissions when the CN tab is not completed.

As the PAE assessor, you likely have access to crucial medical information to support deficits as you list them on the PAE. It is always in the best interest of your organization and the applicant to revise a deficient PAE so that TennCare has the information it needs to make accurate LOC decisions. A revision to support medical necessity should always be completed immediately. Revisions may be submitted up to 30 days after the denial has been issued. A submitter must hit the Revise button in the PAE Tracking System, and then hit the Edit button before changes can be made. After 30 days a new PAE is required.

If on the other hand, you believe that TennCare made a mistake in the review, you should immediately call the TennCare LTSS Help Desk at 877-224-0219 so that the PAE can be reviewed again and any mistakes can be corrected. Each applicant denied NF LOC has the right to appeal the decision. If an appeal is filed by an applicant residing in a NF, the NF must ensure that discharge processes as established by the *Doe* Consent Decree are adhered to. See the TennCare website for additional information about the *Doe* Consent Decree.

15.0 REVISING A PAE

Anytime a PAE is denied for technical reasons, it should immediately be revised (corrected) and resubmitted. If, the PAE is denied because NF LOC criteria are not met, and as the assessor, you agree with the PAE denial, then revision is not necessary. However, if you believe the applicant meets medical eligibility requirements based on the information you have available, but NF LOC is denied by TennCare, you should revise the PAE and submit documentation that is consistent with the level of deficiency indicated. You may also resubmit the PAE with a revised Functional Assessment score that is consistent with the supporting medical documentation.

If NF LOC is denied but “at risk”|| LOC is approved and you believe the applicant may meet the criteria for a safety determination, you may revise the PAE and request a safety determination. Please submit all required and supporting documentation to support the safety determination request.

Deficiencies cured (or remedied) after the PAE is denied but within thirty (30) days of the original PAE submission date as a revised PAE, will be processed as a new application, with reconsideration of the earlier denial based on the record as a whole (including both the original denied application and the additional information submitted with the revised PAE). If approved, the effective date of PAE approval can be no more than ten (10) days prior to the date of receipt of the information which cured the original deficiencies in the denied PAE. Payment will not be retroactive back to the date the deficient application was received or to the date requested in the deficient application.

If more than 30 days have passed, you must submit a new application. TennCare will only include in its review the new PAE application. This means that if there is information from the original PAE that you want reviewed as part of the determination, be sure to also include it in the new PAE submission.

16.0 RECERTIFYING A PAE (NF)

The PAE Tracking System allows users to recertify a previously approved PAE in certain circumstances. The purpose of recertification of a CHOICES PAE differs from the purpose of recertifying a PACE PAE. This section describes the reasons and processes for recertifying both a CHOICES PAE and a PACE PAE.

17.0 Recertifying a NF LOC PAE

The purpose of recertifying a CHOICES PAE is to demonstrate that information submitted on the PAE is still accurate, even though the PAE has not been used for a period of 90 days or more. PAEs do **NOT** need to be recertified every 90 days. However, if you have submitted a PAE and there is more than 90 days between the PAE approval date and the MOPD, the PAE must be recertified to show that the individual continues to meet the level of care represented on the initially submitted and approved PAE. Essentially recertification is a signed statement from the treating physician (PA, NP, or APN as applicable) verifying that the PAE application submitted still accurately represents the needs of the applicant. The PAE Certification Form recertification includes this statement: "I certify that the applicant's medical condition on the recertified PAE is consistent with that described in the initial certification and that Nursing Facility services are medically necessary for the applicant."

When a user enters the MOPD on a PAE and it is more than 90 days from the PAE approval effective date, the PAE Tracking System will prompt the user to recertify the PAE. This is the only time a PAE needs to be recertified. A PAE with no end date can be recertified anytime within 365 days of the initial submission. A PAE with an end date can be recertified, but recertification will never extend a PAE expiration date. A new PAE is required to extend an end dated PAE.

If the applicant's medical condition has changed significantly, such that the previously approved PAE does not reasonably reflect the applicant's current medical condition and functional capabilities, a new PAE is required.

When a PAE is recertified, the original PAE approval effective date is used as the recertified PAE approval effective date.

18.0 APPEALS

The Appeals process is designed to protect the interests and right to due process for Medicaid applicants and beneficiaries. PAE appeal rights are afforded anytime a PAE is denied or when a PAE has been approved with an end date. When a PAE is denied, the applicant (and designee as applicable) are sent a letter. The letter sent to the applicant includes the reason for denial (or end date as applicable) and appeal rights, as well as a statewide list of legal aid offices. TennCare's Division of LTSS also handles specific CHOICES and PACE enrollment appeals regarding the denial of enrollment into these programs, termination of enrollment in one of these programs and/or the denial or termination of Consumer Direction.

A technical denial cannot be appealed. Technical denials require correction of erroneous information by the submitter. Technical denials are expected to be immediately corrected by the submitter. The errors that result in a technical denial are related only to applicant, provider or designee information that is entered incorrectly.

Provider payment disputes do not fall under the purview of TennCare, but instead should be brought to the attention of the MCO or Tennessee's Department of Commerce and Insurance.

18.1 REVIEWING AN APPEAL IN THE PAE TRACKING SYSTEM

If NF level of care is denied, the applicant notice of action includes appeal rights and the time limit within which an appeal may be filed. The time limit for filing an appeal is 30 days plus mailing time. Mailing time includes five (5) days for receipt of the notice mailed by TennCare and may include an additional five (5) days when an applicant's appeal is mailed to TennCare. This means a total of 35-40 days may be allowed for an applicant to timely file a PAE appeal (40 days only when the appeal is mailed to TennCare).

To determine if an applicant has filed a PAE appeal with TennCare, a submitting entity can view the PAE appeal in the PAE Tracking System. Detailed steps are as follows:

1. Locate the patient's PAE in TPAES and open it.
Go to the PAE Request Info Tab.
2. Under General Information, locate the "Current Status" field.
3. If the Current Status is indicated as "Appeal Pending," there is a pending PAE appeal for this applicant. In that case, the applicant may not be involuntarily discharged until such appeal has been resolved. This does not preclude the applicant from a voluntary discharge.

To determine if the time limit for filing an appeal has expired, the submitting entity can view the generated notice of adverse action in the PAE Tracking System. Detailed steps are as follows:

1. Locate the patient's PAE in the PAE Tracking System and open it.
Go to the PAE Related Items Generated Attachments Tab.

2. The letter date is next to the generated attachment listed; or
3. Click on the letter title or icon to view the letter which includes a date in the upper left.

When a PAE appeal is resolved, the Current Status is indicated in TPAES as follows:

- Appeal Overturned Pre-Judgment: Adverse action was overturned prior to hearing and NF level of care is approved.
- Appeal Overturned by Judgment: Adverse action was overturned as a result of the hearing and NF level of care is approved.
- Appeal Upheld by Judgment: Appeal was withdrawn or defaulted, or the adverse action was upheld as a result of the hearing and NF level of care is denied.

18.2 PAE APPROVAL EFFECTIVE DATES BASED ON APPEAL DECISION

It is important to understand that when it is determined during the course of an appeal that the person meets level of care criteria, and such determination is based on *new* information not originally submitted with the PAE such that TennCare's original decision was correct, the earliest effective date of level of care eligibility permitted is the date the deficiency in the original application was cured. This means that if the PAE did not include supporting medical documentation necessary to approve NF level of care, the date that information is received (i.e., the date the deficiency was cured) is the date that must be used in determining the PAE approval effective date on appeal. It is therefore critical that assessors and submitting entities make every effort to ensure that the assessment information submitted in the PAE application accurately reflects the person's level of functioning, and that the medical evidence submitted is consistent with and supports the functional deficits identified in the application.

18.3 NF DISCHARGE REQUIREMENTS UNDER THE *DOE* CONSENT DECREE

In accordance with Section 5(a)(2) of the *Doe v. Word* Consent Decree, whenever a current resident of a nursing home has submitted a PAE for approval of Medicaid reimbursement for NF services, the resident may not be discharged because TennCare initially denied the PAE application until any appeal is resolved or the time during which an appeal may be requested has passed without action. This includes applicants denied for NF level of care, but approved for At Risk LOC.

Once a NF has determined that an appeal has not been filed, and that the time limit for appealing a PAE with TennCare has expired, federally compliant discharge processes may continue. Federal requirements pertaining to NF Discharge and transfer processes can be found at [42 CFR 483.12](#). A copy of the *Doe v. Word* Order can be found on the TennCare website.

18.4 NF REQUEST FOR INFORMATION PROCESS

TennCare has a process to request the immediate attention of a NF when a PAE has been denied, providing 10 calendar days for a NF to submit additional documentation which, if submitted and determined sufficient to approve NF level of care, would preserve the original PAE effective date. Only when the NF *again* fails to submit information sufficient to cure the deficiencies with the PAE would any subsequent approval date, including approval during the pendency of an appeal, be based on the later date that the deficiency is finally cured.

19.0 ABBREVIATIONS

Acceptable Use Policy (AUP)

Activities of Daily Living (ADL)

Advanced Practice Nurse (APN)

Area Agencies on Aging and Disability (AAAD)

Centers for Medicare and Medicaid Services (CMS)

Change of Status (COS)

Chronic Ventilator (CV)

Client Identification (CID)

Cost Effective Alternatives (CEA)

Developmental Disability (DD)

Doctor of Osteopathy (DO)

Enhanced Respiratory Care (ERC)

Federal Benefit Rate (FBR)

Health Insurance Portability Accountability Act (HIPAA)

Home and Community Based Services (HCBS)

Intellectual Disability (ID)

Intermediate Care Facility Individuals with Intellectual Disabilities (ICF-IID)

Intramuscular (IM)

Intravenous (IV)

Level of Care (LOC)

Licensed Practical Nurse (LPN)

Licensed Senior Psychological Examiner (LSPE)

Licensed Social Worker (LSW)

Long Term Services and Supports (LTSS)

Managed Care Organizations (MCO)

Medicaid management Information System (MMIS)
Medical Doctor (MD)
Medicaid Only Payer Date (MOPD)
Mini Mental Status Exam (MMSE)
Minimum Data Set (MDS)
National Provider Identification (NPI)
Non-Invasive Positive Pressure Ventilation (NIPPV)
Nurse Practitioner (NP)
Nursing Facility (NF)
Occupational Therapy (OT)
Patient Controlled Analgesia (PCA)
Physical Therapy (PT)
Physician Assistant (PA)
Pre Admission Evaluation (PAE)
Pre-Admission Screening and Resident Review (PASRR)
Program of All-inclusive Care for the Elderly (PACE)
Registered Nurse (RN)

Saint Louis University Mental Status (SLUMS)

Serious Mental Illness (SMI)

Single Point of Entry (SPOE)

Skilled Nursing Facility (SNF)

Speech Therapy (ST)

Subcutaneous (SQ)

Supplemental Security Income (SSI)

Tracheal Suctioning (TS)

20.0 ATTACHMENTS

Attachment A TENNCARE Level of Care Acuity Scale
Attachment B PAE Certification Form

LTSS PAE Manual

Attachment C	Physician Certification Form
Attachment D	HCBS Applicant Interview Tool
Attachment E	HCBS Collateral Interview Tool
Attachment F	Level 2 Nursing Facility Services
Attachment G	List of Group 3 Services
Attachment H	Safety Determination Request From
Attachment I	Freedom of Choice Form