

## Appendix A: Forms

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- *Montana Medicaid Individual Adjustment Request*
- *Montana Medicaid Claim Inquiry Form*
- *Level I Screen (DPHHS-SLTC-145)*
- *Level of Care Determination (DPHHS-SLTC-86)*
- *Notice of Transfer or Discharge*
- *Monthly Nursing Facility Staffing Report (DPHHS-SLTC-015)*
- *Request For Therapeutic Home Visit Bed Reservation (DPHHS-SLTC-041)*
- *Request For Bed Reservation For Therapeutic Home Visit in Excess of 72 Hours (DPHHS-SLTC-042)*
- *Request for Nursing Facility Bed Reservation During Resident's Temporary Hospitalization (DPHHS-SLTC-052)*
- *Nurse Aide Certification/Training and Competency Evaluation (Testing) Survey Form*
- *Request for Blanket Denial Letter*





# LEVEL I SCREEN

PLEASE READ THE INSTRUCTIONS ON THE SECOND PAGE OF THIS FORM FOR DETAILS.  
HISTORY & PHYSICAL AND LIST OF MEDICATIONS MUST BE INCLUDED WITH THIS FAX.

FAX NUMBER: 1-800-413-3890/443-4585

TELEPHONE NUMBER.: 1-800-219-7035/443-0320

Applicant's Name _____	SSN _____	Date of Birth _____
Diagnosis Primary _____	Physician _____	
Secondary _____	Provider _____	
Other _____	City _____	

Is there a current H & P  Yes  No If no, call Foundation for instructions.

A. MENTAL ILLNESS	YES	NO
1. Does the individual have a diagnosis of serious mental illness (MI)? Diagnosis _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the individual have any indications of a mental illness? If yes, describe. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
3. If the applicant has a diagnosis or indications of mental illness, does the individual have a primary diagnosis of dementia? _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the individual on antipsychotic medication? If yes, what is individual's a) current mental status; b) reason for medications; c) length of time on medications. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Is individual on an antidepressant? If yes, indicate a) history of depression; b) length of depression; c) current depressive status; d) whether depression is situational due to circumstances. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

B. MENTAL RETARDATION OR RELATED CONDITIONS	YES	NO
1. Does the individual have a diagnosis of mental retardation (MR)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the individual have a diagnosis of a related condition (cerebral palsy, autism, seizures, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the individual ever been referred to or served by an agency/institution serving persons with mental retardation or related conditions?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the individual have any indications of mental retardation or a related condition?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the individual have a brain injury? _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

C. INFORMATION SOURCE
The above information has been provided by: Name _____ Date _____
Agency _____ Phone No. _____ Fax No. _____

**FOR FOUNDATION USE ONLY**

D. APPROVED	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Referral for Level II	<input type="checkbox"/> MI	<input type="checkbox"/> MR	<input type="checkbox"/> MI/MR	
MR Referral made to: _____				Date _____
MI Referral made to: _____				Date _____
Comments: _____				
_____				
Name: _____				Date _____

**INSTRUCTIONS:**

- A. Serious mental illness means that the individual is diagnosed according to the criteria specified in DSM-IV as having one of the following conditions: schizophrenia, paranoia, major affective disorder, schizo affective disorder, or atypical psychosis, and does not have a primary diagnoses of dementia, including Alzheimer's disease or a related disorder, which is based on a neurological assessment;

and as a result of the diagnosed mental condition, the applicant presently suffers from significant impairment in at least two of the following functional areas:

1. ability to meet appropriate vocational or homemaker roles for the applicant's current stage of life;
2. ability to maintain community living without dependence on public support systems and monitoring;
3. ability to develop and maintain personal relationships and support systems;
4. ability to meet the normal demands of community living, including self help and self maintenance, freedom of movement, and engaging in a stage-of-life appropriate range of activities;

Indications of mental illness include delusions, hallucinations, incoherence or marked loosening of associations, flat or inappropriate affect, long-standing depressed mood, feelings of worthlessness, excessive or inappropriate guilt, recurrent suicide attempts or ideation, behavior which inflicts injury on self or others, or behavior which presents an imminent threat to self or others.

- B. Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Related conditions means severe, chronic disabilities attributable to cerebral palsy, epilepsy, autism or any other condition, other than mental illness, found to be closely related to MR because the condition results in impairment of general intellectual function or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those required by these persons. It is manifested before the person reaches age 22, is likely to continue indefinitely and it results in substantial functional limitations in three or more of the following areas of major life activities: self care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

- C. Self-explanatory.
- D. Do not fill out. For Foundation use only.
- E. Do not fill out. For Foundation use only.

**LEVEL OF CARE INSTRUCTIONS:**

A Level of Care determination is required prior to Medicaid making payment to a nursing facility or the Home and Community Based Services Program (waiver). Any individual currently eligible, applying, or who intends to apply for Medicaid needs to request a determination. **Submit the SLTC-86 (Level of Care Determination) with at least identifying information via fax or telephone to the Foundation.** The Foundation will notify the applicant, referral source and county Office of Human Services of the results.

### LEVEL OF CARE DETERMINATION

Program Requested:  Nursing Facility  HCBS (Initial)  HCBS YES/Discretionary  Unknown

#### Identifying Information

Applicant : \_\_\_\_\_  
SSN: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Medicaid Status: \_\_\_\_\_  
Veteran:  Yes  No  
County of Application: \_\_\_\_\_  
Nursing Facility Admit Date: \_\_\_\_\_  
Medicare Skilled ? \_\_\_\_\_ Date \_\_\_\_\_  
Previous Medicaid Screen ? \_\_\_\_\_ Date \_\_\_\_\_

Date of Request: \_\_\_\_\_  
Anticipated LOS: \_\_\_\_\_  
Screen Request By: \_\_\_\_\_  
Agency: \_\_\_\_\_ Phone: \_\_\_\_\_  
Applicant Location: \_\_\_\_\_  
Significant Other: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/St/Zip: \_\_\_\_\_  
Other Contacts: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Health Care Professional: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Diagnoses/Summary: \_\_\_\_\_  
\_\_\_\_\_

Special Treatments/Medications/Therapies/Equipment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Social and Other Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dementia:  Yes  No Traumatic Brain Injury:  Yes  No Communication Deficit:  Yes  No

#### For Foundation Use Only

Review Start Date: \_\_\_\_\_  
NF Level of Care:  Yes  No Level I Date: \_\_\_\_\_  
Temporary Stay: \_\_\_\_\_ to \_\_\_\_\_  
RPO Technical Assist:  RPO Onsite:   
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Criteria Met: \_\_\_\_\_

HCBS Referral:  Yes  No Date: \_\_\_\_\_  
CMT: \_\_\_\_\_  
NF Placement: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
 Screener: \_\_\_\_\_ Complete Date: \_\_\_\_\_  
Foundation Contacts: Name and Phone Number  
1) \_\_\_\_\_  
2) \_\_\_\_\_  
3) \_\_\_\_\_  
4) \_\_\_\_\_

Compliance Review  Yes  No By: \_\_\_\_\_ Date: \_\_\_\_\_

cc: Case Management Team \_\_\_\_\_; Nursing Facility \_\_\_\_\_; Referral Source \_\_\_\_\_

## RATING SCALE DEFINITIONS:

Follow this scale when completing the Functional Assessment Portion of the Screen.

- 0 = Independent: The individual is able to fulfill ADL/IADL needs without the regular use of human or mechanical assistance, prompting or supervision.
- 1 = With Aids/Difficulty: To fulfill ADL/IADL, the individual requires consistent availability of mechanical assistance or the expenditure of undue effort.
- 2 = With Help: The individual requires consistent human assistance, prompting or supervision, in the absence of which the ADL/IADL cannot be completed. The individual does however actively participate in the completion of the activity.
- 3 = Unable: The individual cannot meaningfully contribute to the completion of the task.

Follow this scale when completing the Functional Capabilities Portion of the Screen.

- 0 = Good: Within normal limits.
- 1 = Mild Impairment: Some loss of functioning, however, loss is correctable and/or loss does not prevent the individual's capacity to meet his/her needs.
- 2 = Significant Impairment: Loss of functioning that prevents the individual from meeting his/her needs.
- 3 = Total Loss: No reasonable residual capacity.

Coding for Functional Assessment: 0 - Independent 1 - With Mechanical Aids 2 - With Human Help 3 - Unable

**FOUNDATION USE ONLY**

	Current Status/Service	Adequate (circle)	Comments
	Bathing	Yes No	
	Mobility	Yes No	
	Toileting/ Continence	Yes No	
	Transfers	Yes No	
	Eating	Yes No	
	Grooming	Yes No	
	Environmental Modification	Yes No	
	Medication	Yes No	
	Equipment	Yes No	
	Dressing	Yes No	
	Respite	Yes No	
	Shopping	Yes No	
	Cooking	Yes No	
	Housework	Yes No	
	Laundry	Yes No	
	Money Management	Yes No	
	Telephone	Yes No	
	Transportation	Yes No	
	Socialization/ Leisure Activities	Yes No	
	Ability to Summon Emergency Help	Yes No	

Patient Mental Status: (check all appropriate responses) Oriented: Person  Place  Time

Coding for Functional Capabilities: 0 - Good 1 - Mild Impairment 2 - Severe Impairment 3 - Total Loss

- |                              |                            |                           |                                                                                   |
|------------------------------|----------------------------|---------------------------|-----------------------------------------------------------------------------------|
| ( ) Occasionally disoriented | ( ) Inappropriate Behavior | ( ) Medication Misuse     | ( ) Sleep Problems                                                                |
| ( ) Disoriented              | ( ) Confused               | ( ) Alcohol/Drug Misuse   | ( ) Worried/Anxious                                                               |
| ( ) Unresponsive             | ( ) Long Term Memory Loss  | ( ) Isolation             | ( ) Loss of Interest                                                              |
| ( ) Impaired Judgment        | ( ) Short Term Memory Loss | ( ) Danger to Self/Others | 24-Hr Supervision Needed <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ( ) Ambulation _____         | ( ) Hearing _____          | ( ) Speech _____          | ( ) Vision _____                                                                  |

Respiratory Status: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

# NOTICE OF TRANSFER OR DISCHARGE

<b>(Resident's Name)</b>	<b>(Date)</b>
<b>(Nursing facility name)</b>	<b>(Family member/legal representative)</b>
<b>(Nursing facility address)</b>	<b>(Address)</b>

You are being provided this notice to inform you that, for the reasons explained below, you will be transferred or discharged from this facility.

**YOU WILL BE TRANSFERRED/DISCHARGED FOR THE FOLLOWING REASONS:**

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A listing of the permitted reasons for transfer and discharge is found at federal regulation 42 CFR 483.12 (a)(2).

**TRANSFER/DISCHARGE LOCATION: (mark and complete one of the following)**

You will be \_\_\_\_\_ to the following location \_\_\_\_\_  
 (transferred/discharged)  
 \_\_\_\_\_  
 (placement location/facility)

on \_\_\_\_\_ .  
 (Effective date of transfer/discharge)

**OR,**

\_\_\_\_\_ The location to which you will be transferred or discharged is unknown at the time of this notice. This nursing facility will take the following steps to ensure a safe and orderly transfer or discharge from the facility.

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\_\_\_\_\_ Bed hold information has been provided to the resident regarding transfer/discharge.

**BY:** \_\_\_\_\_ **TITLE:** \_\_\_\_\_  
 (Facility Representative Signature)

**ADVOCATES/ ASSISTANCE:**

For assistance in understanding your rights or filing an appeal, you may contact the state long term care ombudsman. The ombudsman’s name and address is KELLY MOORSE, MONTANA LONG TERM CARE OMBUDSMAN, 111 SANDERS STREET, PO BOX 4210, HELENA, MONTANA 59604-4210. THE OMBUDSMAN’S TELEPHONE NUMBER IS 1-800-332-2272.

For assistance in understanding and asserting your rights, if you are developmentally disabled or mentally ill you may contact the Montana Advocacy Program. The Montana Advocacy Program’s address is PO BOX 1681, 400 N PARK AVENUE, 2nd floor, HELENA, MT 59624-1681. THE MONTANA ADVOCACY OFFICE’S TELEPHONE NUMBER IS 1-800-245-4743 or (406) 449-2344.

**FAIR HEARING RIGHTS:**

If you disagree with the facility’s decision to transfer or discharge you, YOU MAY REQUEST A HEARING WITHIN 30 DAYS of the date of this letter. A hearing may be requested for you, by a family member, a friend, legal counsel, an advocate, or other representative of your choice. Your request must be mailed or delivered to:

Office of Fair Hearings  
Department of Public Health and Human Services  
PO Box 202953  
2401 Colonial Drive, 3rd Floor  
Helena, Montana 59620-2953

Upon receipt of your timely request, a hearings officer will be appointed by the Department of Public Health and Human Services to hear your case and issue a decision. You will be contacted by the hearing officer regarding scheduling of a hearing. You have the right to represent yourself at the hearing or to use legal counsel, an advocate, a relative, a friend or another person to represent you.

The facility’s decision to transfer or discharge you does not affect your Medicaid eligibility. If you have any questions regarding Medicaid coverage of services in the setting to which the facility proposes to transfer or discharge you, please contact your local county office of human services or the department’s Senior and Long Term Care Division at (406) 444-4077.

**REQUEST FOR A FAIR HEARING:**

If you would like to request a fair hearing you may fill out the information below and mail it to the above address.

**TO: Fair Hearings Officer: I would like to request a Fair Hearing to appeal the decision to transfer/discharge me from a nursing facility.**

\_\_\_\_\_  
(Nursing Facility Name)

\_\_\_\_\_  
(Resident’s Name)

\_\_\_\_\_  
(Requestor’s name [if different than resident’s] please print)

\_\_\_\_\_  
(Requestor’s Signature)

\_\_\_\_\_  
(Date of Request)

\_\_\_\_\_  
(Requestor’s Address)

\_\_\_\_\_  
(Telephone Number)

## MONTHLY NURSING HOME STAFFING REPORT

### MONTANA STATE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Nursing Facility Services Bureau  
PO Box 4210  
Helena, MT 59604-4210  
Phone 406-444-4077 FAX 406-444-7743

**FACILITY NAME:** \_\_\_\_\_ **Provider #** \_\_\_\_\_

**FACILITY ADDRESS:** \_\_\_\_\_ **City** \_\_\_\_\_

**MONTH ENDING:** \_\_\_\_\_

**STAFFING REQUIREMENT:** Facilities must provide staffing at levels which are adequate to meet federal law, regulations and requirements.

**HOURS/EMPLOYEES DURING REPORTING PERIOD:**

Please list the total number of hours worked and number of employees in each of the listed categories for the month:

	TOTAL EMPLOYEE HOURS	TOTAL CONTRACT HOURS	TOTAL HOURS WORKED		NUMBER OF FACILITY EMPLOYEES	NUMBER OF CONTRACT STAFF	TOTAL NUMBER OF RN, LPN, CNA
<b>RN'S</b>				<b>RN'S</b>			
<b>LPN'S</b>				<b>LPN'S</b>			
<b>CNA / AIDES:</b>				<b>CNA / AIDES:</b>			
<b>TOTAL</b>				<b>TOTAL</b>			

Note: Include all RN, LPN and AIDE hours for direct care staff. Director of Nursing hours may be included if spent dispensing meds, on rounds or charting - do not include administrative hours. Do not include time spent on in-service training, time for laundry or maintenance staff even if they are certified as aides or other non-direct care staff. Contract employees / hours are direct care hours provided by agency staff, temp. service staff, etc. who are not employees of the facility.

**PATIENT DAYS:**

Please list the total number of occupied days by each category for the month:

LEVEL OF CARE	MEDICAID	MEDICARE	LONG TERM CARE INSURANCE	VETERANS	PRIVATE PAY	OTHER (Work Comp Ins., Auto Ins, Medigap Ins, etc)	TOTAL
Skilled Care (SNF)							
Nursing Care (NF)							
Hospice							
Billable Bed Holds							
Other							
<b>TOTAL (5 rows)</b>							
Medicare Co-Insurance Payments (duplicated )							

**CERTIFICATION:**

I certify that this information, to the best of my knowledge, is true, accurate, and complete:

Signed: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_

MAIL THIS FORM TO: SENIOR AND LONG TERM CARE DIVISION, PO BOX 4210, HELENA, MT 59604-4210

TIME LINE: This form is to be submitted to the department within 10 days following the end of each calendar month.

## **STAFFING REPORTS (DPHHS-SLTC-015):**

Staffing Report information is used to document occupancy levels for budget projections. It is very important that it be filled out accurately and submitted by the 10<sup>th</sup> of the month. *Please mail or FAX completed forms to the Senior & Long Term Care Division using information on the top of the form.*

### **Hours/Employee Info:**

The information on nursing staff hours and numbers of employees is being collected for statistical purposes. However, if staffing level information or reporting should ever become mandated, this is the documentation that will be used to track compliance with staffing minimums.

1. The staffing hours that should be reported are direct patient care hours as described on the form. Under number of employees we want actual numbers of people providing the service not FTE's (Full Time Equivalent).
2. If a facility uses contract staff (i.e. pool staff, travelers, temporary agency staff, etc.), those hours and people should be reported as well since they contribute to patient care. The facility should list these hours and individuals under contract hours and staff, in the category of employee that is being contracted for.
3. When the data is compiled an FTE calculation will be made. Occasionally there may be overtime situations where the FTE will be greater than the number of employees. If the FTE calculation is significantly more than the number of employees reported we will ask the facility to double check the figures for accuracy.

### **The 'Patient Days' section:**

Tracks census days by payee classification. Payer source is across the top and level of care is down the side.

- 1) Level of care: SNF (Skilled Nursing Facility) meets the Medicare requirements for skilled care.
  - Medicare days should be reported on the SNF line unless they are exceptions to the skilled criteria (such as hospice).
  - Medicaid days meet the requirements for billing Medicaid and are either skilled care (SNF) or intermediate care (NF) or billable hold days (Bed Hold), (Hospice) these days are paid by the hospice provider for Medicaid eligible residents. Use (other) for non-billable but unavailable bed days (such as hospital hold days when facility is not full with a waiting list)
- 2) Payer source: Medicaid, Medicare, Long Term Care Insurance, Veterans, Private Pay or Other. The 'Other' category includes all payer sources not individually listed (i.e. auto insurance, workers comp. insurance, etc.)
  - Please do not double report bed days in the first 5 lines - choose the most appropriate category and use that. (i.e. the primary payer)
  - If a resident is dually eligible and Medicaid is being billed for co-pay days, enter the days under Medicare and on line 7 (Medicare Co-Insurance row), in the Medicaid column. If the resident is Medicare with private pay or private insurance then enter the days under Medicare and the co-insurance in the appropriate payer column / Medicare co-insurance row.
  - Do not report co-pays or non-covered services under private pay.
  - The total bed days, reported in the first five (5) lines, will be divided by the number of days in the month for an average occupancy and compared to your facility's licensed beds.

Please use these criteria for filling out the staffing report from now on. There is no need to revise previously submitted forms. If you have any questions please feel free to contact SLTC (see key contacts in this manual).

LEVEL OF CARE	MEDICAID	MEDICARE	LONG TERM CARE INSURANCE	VETERANS	PRIVATE PAY	OTHER (Work Comp Ins., Auto Ins, Medigap, etc)	TOTAL
Skilled Care (SNF)		<i>Most if not all Medicare Days will be entered here.</i>					
Nursing Care (NF)							
Hospice	<i>Hospice provider pays for Medicaid eligible Resident</i>						
Bed Holds	<i>Billable Bed Holds (THV &amp; HH)</i>						
Other	<i>Non-Billable Bed Holds (HH if not full and THV &gt; 24 days or not pre-approved &gt; 72 hr visits)</i>						<i>This total divided by days in month to calculate avg. occupancy</i>
TOTAL (lines 1-5)							
Medicare Co-Insurance Payments (duplicated reporting)	<i>Medicare co-ins. days for dually eligible residents</i>		<i>Co-insurance days for Medicare covered days (21-100)</i>			<i>Co-insurance days for Medicare covered days (21-100)</i>	

Please use these criteria for filling out the staffing reports. If you have any questions please feel free to contact SLTC (see Key Contacts in this manual).

## Bed Hold Forms

The 24-day allotment for THV's (Therapeutic Home Visits) begins July 1 and ends June 30. Submit forms to the address on the form.

It is the facility's responsibility to make sure that all forms are signed and received by the Senior and Long Term Care Division within 90 days of the first day of the resident's visit or hospitalization. Most forms will be returned to the facility within a two week time period. If you have not received your forms, you may want to call Senior and Long Term Care and make sure that the Department received your request. For more information on obtaining authorization for these services, see the *Prior Authorization and PASSPORT* chapter in this manual. If you have any questions regarding these forms call 406-444-4077 or 406-444-3997.

### ***DPHHS-SLTC-041 Request for Therapeutic Home Visits under 72 hours***

Use this form when a resident leaves the facility for under 72 hours (3 days). Complete the DPHHS-SLTC-041 monthly and send the yellow copy (or photocopy) to the Nursing Facility Services Bureau (see *Key Contacts*). In order to be reimbursed for these visits, this form must be received in our office within 90 days of the resident's first day of absence. The facility will not receive a return copy of this form unless a problem arises.

### ***DPHHS-SLTC-042 Request for Therapeutic Home Visits in excess of 72***

Use this form when a resident leaves the facility longer than 72 hours (3 days). A visit that is over 72 hours must be prior-authorized by the resident's physician and the Department **before** the resident leaves the facility. Prior authorization can be obtained by calling 406-444-3997 or 406-444-4077 or by sending the SLTC-042 to the Department before the date of departure. A prior authorization by telephone is only valid if the department also receives the DPHHS-SLTC-042 form within 90 days. If you send the DPHHS-SLTC-042 form in without prior-authorization by telephone, it must be received by the Department before the resident leaves the facility. In order to be reimbursed for these days, the form must be submitted within 90 days from the resident's first day of absence and signed by an authorized designee of the Senior and Long Term Care Division. If prior authorization is not obtained for a THV in excess of 72 hours, the entire visit will be denied and any reimbursement made for these days will be recovered. Please send in the white and yellow copies (or two photo copies). The facility will receive the white copy back with the signature of the authorized designee.



Medicaid does not pay for more than 24 THV days in a state fiscal year (July 1 - June 30).

If the resident leaves the facility unexpectedly on the weekend for a visit longer than 72 hours, you must call in on the next business day to receive prior authorization. If a resident left the facility on a visit and is unexpectedly delayed, you must telephone the Department and either get a prior authorization if the visit is going to be over 72 hours or obtain an extension for the visit. THV's cannot exceed 24 days in a period from July 1 through June 30.

### ***DPHHS-SLTC-052 Request for Bed Hold During Hospitalization***

Use this form when a Medicaid resident is temporarily receiving medical treatment in another facility (usually a hospital; not another nursing facility or swing bed), but is expected to return to the facility. This form must be submitted within 90 days of the resident's first day of absence and it must be accompanied by a current waiting list. Please send the white and yellow copies (or two photo copies) to the Department. The facility will receive the white copy back with the authorizing signature. Facilities may only bill for hospital hold days if they are currently full with a waiting list.

**REQUEST FOR THERAPEUTIC HOME VISIT BED RESERVATION**

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**(NAME OF FACILITY)**

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**(ADDRESS OF FACILITY)**

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**(FACILITY ID NUMBER)**

I certify that a bed is being held for the following resident(s) and the care plan for each resident listed provides for therapeutic home visits. I understand there is a seventy-two (72) hour limitation per visit and a limit of twenty-four (24) days annually. Longer hours per absence must be prior authorized.

NAME OF RESIDENT	SOCIAL SECURITY NUMBER	ABSENT		TOTAL DAYS USED YEAR TO DATE	NAME OF ATTENDING PHYSICIAN
		FROM	TO		

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**(SIGNATURE OF ADMINISTRATOR / DESIGNEE)**      **(DATE)**      **(AUTHORIZING SIGNATURE)**      **(DATE)**

**INSTRUCTIONS**

If residents listed are within the twenty-four (24) day annual limit and this visit is no more than seventy-two (72) hours, mail **copy only** to the Senior and Long-Term Care Division. Keep original for your file. Submit on a monthly basis. Request must be submitted to the Department within 90 days after the first day of the requested bed hold period.

Prior authorization requests for absences in excess of the 72-hour per visit limitation must be submitted to the Senior and Long-Term Care Division, Department of Public Health and Human Services for review and authorization. (See form DPHHS-SLTC-042).

"Total Days Used Year To Date" refers to the State Fiscal Year (July 1 - June 30).

To compute the number Therapeutic Home Visit days used on this visit, **do** count the day the resident leaves – **do not** count the day of return. Add the days of the current visit, to days used previously in the fiscal year (July 1 to June 30), for Total Days Used Year to Date. Example: If a resident leaves Friday and returns Sunday, the days absent are counted as two (Friday and Saturday). For billing instructions please refer to the Nursing Facility Services Manual.

**REQUEST FOR BED RESERVATION FOR THERAPEUTIC  
HOME VISIT IN EXCESS OF 72 HOURS**

\_\_\_\_\_  
(NAME OF FACILITY)

\_\_\_\_\_  
(ADDRESS OF FACILITY)

\_\_\_\_\_  
(FACILITY ID NUMBER)

I certify that a bed is being held for the following resident and the care plan for this resident provides for therapeutic home visits. I understand that this request for a therapeutic home visit in excess of 72 hours must be prior authorized and that there is a limit of 24 days annually.

NAME OF RESIDENT	SOCIAL SECURITY NUMBER	ABSENT		TOTAL DAYS USED YEAR TO DATE	NAME OF ATTENDING PHYSICIAN
		FROM	TO		

REASON FOR REQUEST: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of Administrator / Designee: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY THE SENIOR AND LONG TERM CARE DIVISION, DEPARTMENT OF PHHS.**

Authorized                       Not Authorized                      Date: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Authorizing Signature)

\_\_\_\_\_  
(Date)

**INSTRUCTIONS**

This request must be referred to the Senior and Long Term Care Division, Nursing Facility Services Bureau, P.O. Box 4210, Helena, Montana 59604-4210, for review and prior authorization. Prior authorization can be obtained by calling the Department or by sending the SLTC-042 before the date of departure. If the form is mailed, it must be received by the department prior to the first day of the visit if not prior authorized by phone. The visit must be prior authorized before the resident leaves the facility. The completed form **must** be submitted to the Department within 90 days after the first day of the requested bed hold period. The original, with authorization signature or denial, will be returned for your records. A copy will be retained by SLTC Division, DPHHS.

"Total Days Used Year To Date" refers to the State Fiscal Year (July 1 - June 30).

Enter the date the resident leaves in the 'From' column and the date the resident returns in the 'To' column. To compute the number Therapeutic Home Visit days used on this visit, **do** count the day the resident leaves – **do not** count the day of return. . Example: if resident leaves Friday and returns Tuesday, the days absent are counted as four (Friday, Saturday and Sunday, Monday). Add the days of the current visit, to days used previously in the fiscal year (July 1 to June 30), for Total Days Used Year to Date. For billing instructions please refer to the Nursing Facility Services Manual.



# Sample Only

## NURSE AIDE CERTIFICATION/TRAINING AND COMPETENCY EVALUATION (TESTING) SURVEY FORM

**Directions:** Please provide the following information related to documentable nurse aide certification training and competency evaluation (testing) costs for the **FY 2005 1<sup>st</sup> quarter, July 1, 2004 through September 30, 2004**. The costs are divided into four categories:

1. Equipment and Supplies - Includes materials purchased that directly relate to providing certification training. A self-paced instructional package such as ProCare is an example of this kind of material. Purchases should be supported by documentation in the form of receipts or purchase orders.
2. Facility Personnel Costs - Includes costs for wages and benefits of facility personnel who **provide certification training**. Expenditures in this category should be documented through time sheets, payroll records or other appropriate ways of tracking staff activities.  
Consistent with Federal guidelines, this category **does not include salaries of nurse aides in training or replacement aides** for those in training or testing status; **nor does it include required ongoing education**.

Salaries of NF administrators or other NF personnel are not to be considered unless they are conducting the state-approved, in-house training program. In that instance, the portion of the person's salary that is attributable to the Nurse Aide Training and Competency Evaluation Program (NATCEP) is claimable as an administrative cost.

No indirect costs, i.e., supervisory time or any other allocated indirect cost, may be claimed. Only direct salaries, utilities, space, etc. (space must be 100 percent dedicated to training functions) required to provide training/testing may be claimed. All directly allocable costs, including space, utilities, and salaries of personnel not involved full time in this task, must be documented to support an acceptable allocation methodology between nursing facility operations and NATCEP.

3. Sub-Contracted Services - Includes non-facility personnel or other costs associated with providing training. Examples include tuition expenses, consultant costs, and travel expenses for nurse aides who travel to other locations for training, and nurse aide reimbursement costs. Expenditures in this category should be documented through invoices, receipts, purchase orders or contracts.
4. Competency Evaluation/Testing - Includes cost of actual testing required for nurse aides, incurred at the facility and, in the case of competency evaluation (testing) costs for providers that are not testing entities, incurred in payment of a qualified testing entity's fee for competency evaluation (testing).

**Amount:** List the total amount incurred for each category of expenditure.

**Description:** Provide a brief explanation of what is contained in this category of expenditure. (i.e. Procare, Training Tapes, Consultant Fees, Testing Fees etc.)

# Sample Only

**First Quarter FY 2005 Costs (July 1, 2004 through September 30, 2004)**

Please return completed form by **November 1, 2004** to:

Becky McAnally, Human Services Specialist  
Senior and Long Term Care Division  
Department of Public Health and Human Services  
P.O. Box 4210  
Helena, MT 59604-4210

**EFFECTIVE JULY 1, 1998 TESTING FEES PAID TO HEADMASTER WILL BE INCLUDED ON THIS FORM.**

CATEGORY	AMOUNT	DESCRIPTION
1. Supplies and Equipment:	\$	
2. Facility Personnel:	\$	
3. Sub-Contracted Services:	\$	
4. Number of CNAs Trained During Quarter:		
5. Competency Evaluation Testing	\$	
6. Number of CNAs tested during Quarter:		
Signature of Administrator:		
Facility:		
Facility Medicaid Provider #	City:	

**ARM 37.40.322 (2)(b) states "if a provider fails to submit the quarterly reporting form within 30 calendar days following the end of the quarter, the department may withhold reimbursement payments in accordance with ARM 37.40.346 (4)(c). All amounts so withheld will be payable to the provider upon submission of a complete and accurate nurse aide certification/training survey reporting form."**

## **Contacts for further information about NATCEP or CEP**

Questions about the nurse aide registry and state-approved NATCEP and CEP programs should be directed to the Division of Quality Assurance, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951. Telephone - (406) 444-2037 (*or 406-444-4980*) *or* go to the Nurse Aide Registry link on the Department of Public Health and Human Services website at [www.dphhs.state.mt.us](http://www.dphhs.state.mt.us).

Questions about Medicaid reimbursement should be directed to the Senior & Long Term Care Division of the Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; Telephone – (406) 444-4077.

**REQUEST FOR BLANKET DENIAL LETTER**

**DATE REQUESTED** \_\_\_\_\_ **PROVIDER #** \_\_\_\_\_

**RECIPIENT NAME** \_\_\_\_\_

**MEDICAID ID #** \_\_\_\_\_

**INSURANCE COMPANY NAME ON FILE** \_\_\_\_\_

**PROCEDURE CODES NEEDED:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**CONTACT** \_\_\_\_\_

**PHONE NUMBER** \_\_\_\_\_

**FAX NUMBER** \_\_\_\_\_

**PLEASE FAX ALL REQUESTS TO 406-442-0357**

# Paperwork Attachment Cover Sheet

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**Paperwork Attachment Control Number:** \_\_\_\_\_

**Date of service:** \_\_\_\_\_

**Medicaid provider number:** \_\_\_\_\_

**Medicaid client ID number:** \_\_\_\_\_

**Type of attachment:** \_\_\_\_\_

## **Instructions:**

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website [www.mtmedicaid.org](http://www.mtmedicaid.org). If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.