



State of Tennessee
Department of Finance and Administration
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

Phil Bredesen
Governor

M.D. Goetz, Jr.
Commissioner

URGENT MEMO

DATE: June 19, 2009
TO: Administrators and Directors of Nursing
Intermediate and Skilled Nursing Facilities
FROM: Patti Killingsworth
Chief of Long Term Care
Cc: Darin Gordon, TennCare Director
Scott Pierce, Chief Financial Officer
Mollie Mennell, Deputy of LTC Quality and Administration
Nita Mangum, Deputy of LTC Eligibility and Enrollment
Pat Santel, Director of LTC Institutional Services
Debbie Coleman, RN, PAE Nurse Unit Manager
Kim Carroll, LTC Claims Unit Manager
SUBJECT: NEW PAE FORM and CHECKLIST

I trust that everyone has read the **URGENT MEMO** faxed on June 5th and again on June 8th regarding **IMPORTANT PASRR and PAE Changes Effective July 1, 2009.**

In addition to the **new PASRR screening form** that was attached to the memo, we have also developed a **new PAE application. Facilities must begin using the new PAE application on July 1, 2009.** As earlier advised, the newly revised PAE is now a stand-alone document and no longer includes the PASRR screen. As a reminder, **if you are seeking Medicaid reimbursement, both the PAE application and PASRR screen forms MUST be submitted before the PAE can be approved.**

You will recall that, among the changes that will be effective on July 1, 2009, **any deficiencies in the submitted PAE application** (e.g., missing information, including signatures and required documentation) **must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.**

Deficiencies cured *after* the PAE is denied but within 30 days of the original PAE submission date 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). If approved, the effective date of PAE approval can be no earlier than 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.

PLEASE NOTE:

Once a PAE has been denied, the original denied PAE application must be resubmitted along with any additional information which cures the deficiencies of the original application. Failure to include the original denied application may delay the availability of Medicaid reimbursement for nursing facility services.

In an effort to help facilities minimize the submission of incomplete PAEs and avoid technical denials, modifications have been made to the new PAE application. These changes are intended to assist you in submitting a “complete” PAE application. They include:

- 1) Additional in-place instructions, e.g., on pages 2 and 3, “Complete ALL functional areas; circle ONLY ONE answer for each functional area.”
- 2) On pages 2 and 3, for each functional area listed, additional clarification is provided regarding the meaning of each of the available responses: Always, Usually, Usually Not and Never.
- 3) On page 4, below each skilled or rehabilitative service, we have specified in “*Italics*” the documentation that must be submitted for the particular skilled or rehabilitative service requested.

In addition, the following changes have been made:

- 4) On page 5, under Required Attachments, *in addition* to the History and Physical, we will now accept other recent medical records supporting the applicant’s functional and/or skilled nursing or rehabilitative needs signed by the physician, nurse practitioner or physician’s assistant.
- 5) The certification of assessment (signed by the person completing or “certifying” the assessment) may be completed by a physician, nurse practitioner, physician assistant, registered or licensed nurse, or licensed social worker. The certification of level of care must still be signed by a physician.

Finally, we have developed a PAE checklist that facilities may use *prior to* submitting the PAE in order to review the application and ensure that: (1) all required elements have been completed; and (2) all required documentation is attached. The PAE checklist is for the benefit of the user and SHOULD NOT be submitted with the PAE.

IMPORTANT REMINDER:

As a reminder, I urge you to review the June 5th memo and ensure that all staff are informed of these changes, including:

- **PASRR screening forms must be completed and submitted to TennCare prior to admission** for ALL individuals seeking admission to a certified NF.
- **Nursing facilities will have up to 10 days after date of admission OR up to 10 days after the requested effective date of TennCare reimbursement (which cannot be prior to admission) to submit the PAE.**
- **Thirty (30)-day retroactive reimbursement of NF services will no longer be provided.**
- **The earliest date of Medicaid reimbursement for NF services is the date that ALL of the following criteria are met:**
 - 1) Effective date of level of care eligibility by TennCare (i.e., effective date of the PAE), which cannot be more than 10 days prior to date of submission of the approvable PAE;
 - 2) Effective date of Medicaid eligibility (in most cases, the date of DHS application); and
 - 3) Date of NF admission.

If you have any questions regarding these changes, please feel free to contact the TennCare Division of Long-Term Care, PAE Nurse Unit at 615-507-6964 or 1-877-224-0219.

PREADMISSION EVALUATION CHECKLIST

The following checklist is to aid users in submitting a **complete PAE application**.

Submission of an *incomplete* PAE may result in processing delays or in denial of the PAE.

Effective July 1, 2009, **any deficiencies in a submitted PAE application (e.g., missing information, including signatures and required documentation) must be cured prior to disposition of the PAE to preserve the PAE submission date for payment purposes.** Deficiencies cured *after* the PAE is denied but within 30 days of the original PAE submission date 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). If approved, the effective date of PAE approval can be no earlier than 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.

NOTE: Completion of all elements on the checklist does not guarantee approval of the PAE; the applicant must satisfy medical eligibility requirements for long-term care services.

Document	Required Elements
PAE Page 1	<ul style="list-style-type: none"> <input type="checkbox"/> Is Service Requested checked? <input type="checkbox"/> Is Applicant name, address, date of birth, SSN and Medicaid ID (if applicable) completed? <input type="checkbox"/> Is Designee name, address and phone number completed OR is certification that applicant that does not want a designated correspondent <u>checked AND signed by applicant</u>? <input type="checkbox"/> Is LTC Provider name, phone and fax completed? <input type="checkbox"/> Is Provider Number specified (must match provider # for Level I or Level II NF, if applicable)? <input type="checkbox"/> Is Submitting Agency name, phone and fax completed (if other than provider)? <input type="checkbox"/> Is Submission Type specified?
PAE Pages 2-3	<ul style="list-style-type: none"> <input type="checkbox"/> Is a response provided for <u>all</u> functional areas even if applicant has no deficits in a particular area (<i>except</i> Incontinence, Indwelling Catheter/Ostomy and Insulin, if not applicable)? <input type="checkbox"/> If Medications is marked UN or N, are specific medications and explanation regarding why applicant is unable to self-administer medications with limited help from others provided? <input type="checkbox"/> If Insulin is marked UN or N, is explanation regarding why applicant is unable to inject insulin with a pre-filled syringe or draw up and inject sliding scale insulin provided? <input type="checkbox"/> If Behavior is marked A or U, are the specific behavioral problems requiring continual staff or caregiver intervention specified?
PAE Page 4 Level 2 Requests	<ul style="list-style-type: none"> <input type="checkbox"/> Is each applicable skilled or rehabilitative service checked <u>and the frequency</u> of each service specified? <input type="checkbox"/> Is required supporting documentation (as listed on page 4) for <i>each</i> skilled or rehabilitative service requested attached?
PAE Page 5	<ul style="list-style-type: none"> <input type="checkbox"/> Is the Certification of Assessment signed and dated by a Physician, NP, PA, RN, LPN or LSW, and the professional credentials (e.g., M.D., D.O., R.N., etc.) specified? <input type="checkbox"/> Are diagnoses relevant to the applicant's functional and/or skilled nursing needs (as reflected on the PAE) specified? <input type="checkbox"/> Is the PAE Request Date, if different from physician's certification date, specified? <input type="checkbox"/> Is the PAE Certification signed and dated by the physician? <input type="checkbox"/> When submitting a previously approved PAE for an update, is the revised request date, physician's signature and new date of signature completed?
History and Physical Exam	<ul style="list-style-type: none"> <input type="checkbox"/> Is a recent History and Physical (completed within 365 days of the PAE Request Date or date of Certification of Level of Care on page 5, whichever is earlier) OR other medical records supporting the applicant's functional and/or skilled nursing or rehabilitative needs <u>attached AND signed</u> by the physician, nurse practitioner or physician's assistant?
Physician Orders	<ul style="list-style-type: none"> <input type="checkbox"/> Are Physician Orders (current for the PAE Request Date or Revised PAE Request Date) attached?

PREADMISSION EVALUATION (PAE) FOR LONG-TERM CARE

FOR TENNCARE USE ONLY:

APPROVAL DECISION	LEVEL OF CARE	APPROVAL DATE	END DATE	REVIEWER	REVIEW DATE
YES NO	1 2 H P	_____ --	_____	_____	_____
YES NO	1 2 H P	_____ --	_____	_____	_____
YES NO	1 2 H P	_____ --	_____	_____	_____
YES NO	1 2 H P	_____ --	_____	_____	_____

SERVICE REQUESTED:

[] Nursing Facility – Level 1 Care [] Nursing Facility – Level 2 Care [] PACE Program [] HCBS E & D Waiver

APPLICANT Name (Last, First, Middle) _____ Date of Birth _____
 Street Address _____
 City _____ State _____ Zip _____
 SSN _____ - _____ - _____ **AND** Medicaid Number (if currently eligible) _____

DESIGNEE Name (Last, First, Middle) _____
 Street Address _____
 City _____ State _____ Zip _____
 Phone Number(s) _____

Applicant MUST identify the person that s/he wants to receive information about this application OR sign below to show that s/he chooses not to have anyone else receive this information:

I certify that I do NOT want a designated correspondent. _____
(Applicant Signature)

LONG TERM CARE PROVIDER
 (Nursing Facility, PACE or AAAD)
 Name _____ Contact Name _____
 Street Address _____
 City _____ State _____ Zip _____
 Provider Number _____ Phone _____ Fax _____

If the SUBMITTING AGENCY is *other than* the Provider listed above, the following must be completed:

SUBMITTING AGENCY
 Name _____ Contact Name _____
 Street Address _____
 City _____ State _____ Zip _____
 Provider Number _____ Phone _____ Fax _____

- SUBMISSION TYPE**
- New PAE
 - Previously submitted PAE (also check one of the following)
 - Certification Update (update PAE to extend 90 day date)
 - Response to a denied PAE
 - Correction of information (SSN, Request Date, etc.)

Return Completed	Bureau of TennCare, Division of Long Term Care	
Form to:	<u>By FAX:</u>	615-741-9260
	<u>By U.S. Mail:</u>	P.O. Box 450, Nashville, TN 37202-0450
	<u>By Other Delivery:</u>	310 Great Circle Road, Nashville, TN 37243

FUNCTIONAL ASSESSMENT (Complete ALL functional areas; circle ONLY ONE answer for each functional area):

A=Always; U=Usually; UN=Usually Not; N=Never

I. TRANSFER

Can applicant transfer without physical help from others?

- A. Applicant is **always able** to self transfer without physical help from others.
- U. Applicant **requires cueing, stand-by assistance and/or supervision** to transfer, **OR** requires **contact guard assistance and/or hands-on physical assistance 1-3 days per week.**
- UN. Applicant **requires contact guard assistance and/or hands-on physical assistance 4 or more days per week.**
- N. Applicant is **never able** to transfer without physical help from others.

II. MOBILITY

Can applicant walk without physical help from others?

- A. Applicant is **independent** with walking.
- U. Applicant **requires cueing, stand-by assistance and/or supervision** to walk, **OR** requires **physical assistance 1-3 days per week.**
- UN. Applicant **requires physical assistance 4 or more days per week** to walk.
- N. Applicant is **never able** to walk without physical help from others.

Can applicant self-propel a wheelchair without physical help from others?

NOTE: Response is required IF applicant is usually not (UN) or never (N) able to walk without physical help from others.

- A. Applicant is **always able** to self-propel a wheelchair without physical help from others.
- U. Applicant **requires physical assistance 1-3 days per week** to propel a wheelchair.
- UN. Applicant **requires physical assistance 4 or more days per week** to propel a wheelchair.
- N. Applicant is **never able** to self-propel a wheelchair without physical help from others.

III. EATING

Can applicant place food/drink in the mouth without physical help from others?

- A. Applicant is **independent** with placing food/drink in the mouth.
- U. Applicant **requires physical assistance 1-3 days per week** to place food/drink in the mouth.
- UN. Applicant **requires physical assistance 4 or more days per week** to place food/drink in the mouth.
- N. Applicant is **never able** to place food/drink in the mouth without physical help from others.

IV. TOILETING

Can applicant use a toilet without physical help from others?

- A. Applicant is **independent** in toileting.
- U. Applicant **requires physical assistance 1-3 days per week** to toilet.
- UN. Applicant **requires physical assistance 4 or more days per week** to toilet.
- N. Applicant is **never able** to use a toilet without physical help from others.

IF INCONTINENT: Can applicant perform incontinence care without physical help from others?

Check Type(s): [] Bowel [] Bladder

- A. Applicant is **independent** with incontinence care.
- U. Applicant **requires physical assistance 1-3 days per week** with incontinence care.
- UN. Applicant **requires physical assistance 4 or more days per week** with incontinence care.
- N. Applicant is **totally dependent** on others for incontinence care.

IF INDWELLING CATHETER or OSTOMY is present, can applicant perform self-care without physical help from others?

- A. Applicant is **independent** with indwelling catheter or Ostomy care.
- U. Applicant **requires physical assistance 1-3 days per week** with indwelling catheter or Ostomy care.
- UN. Applicant **requires physical assistance 4 or more days per week** with indwelling catheter or Ostomy care.
- N. Applicant is **totally dependent** on others for indwelling catheter or Ostomy care.

V. ORIENTATION

Is applicant oriented to both PERSON (remembers name; recognizes family) AND PLACE (knows where s/he is and able to locate common areas in living environment)?

- A. Applicant is **always oriented** to both person and place.
- U. Applicant is **usually oriented** to both person and place (becomes disoriented to person and/or place 1-3 days per week).
- UN. Applicant is **usually not oriented** to person and/or place (becomes disoriented to person and/or place 4 or more days per week).
- N. Applicant is **never oriented** to person and/or place.

FUNCTIONAL ASSESSMENT (Complete ALL functional areas; circle ONLY ONE answer for each functional area):
A=Always; U=Usually; UN=Usually Not; N=Never

VI. COMMUNICATION

EXPRESSIVE: Can applicant express basic wants and needs?

- A. Applicant is **always able** to express basic wants and needs using verbal or written language or assistive communication device.
- U. Applicant is **usually able** to communicate basic wants/needs using verbal/written language or assistive communication device (requires assistance 1-3 days per week).
- UN. Applicant is **usually not able** to communicate basic wants/needs using verbal/written language or assistive communication device (requires assistance 4 or more days per week).
- N. Applicant is **never able** to communicate basic wants/needs.

RECEPTIVE: Can applicant understand and follow very simple instructions (e.g., perform basic activities of daily living such as dressing or bathing) without continual staff or caregiver intervention?

- A. Applicant is **always able** to understand and follow very simple instructions.
- U. Applicant is **usually able** to understand and follow very simple instructions (1-3 days per week).
- UN. Applicant is **usually not able** to understand and follow very simple instructions (4 or more days per week).
- N. Applicant is **never able** to understand and following very simple instructions.

VII. MEDICATIONS – Includes: PO, IV, IM, Enteral, Rx otics, optics, topicals, inhalers and continuous SQ pain management

Is applicant physically or mentally able to self-administer medications with limited help from others (e.g., reminding, encouraging, reading labels, opening bottles, handing to applicant, monitoring dosage)?

- A. Applicant is **always physically and mentally capable** of self administering prescribed medications.
- U. Applicant is **usually physically and mentally capable** of self administering prescribed medications with limited assistance (requires assistance with administration of prescribed medications 1-3 days per week).
- UN. Applicant is **usually not physically and/or mentally capable** of self administering prescribed medications despite the availability of limited assistance (requires assistance with administration of prescribed medications 4 or more days per week).
- N. Applicant is **never able** to self administer prescribed medications, despite the availability of limited assistance.

NOTE: If 'UN' or 'N' is marked, please list medications for which assistance is needed, and provide explanation regarding why applicant is unable to self administer with limited help from others _____

INSULIN ADMINISTRATION only: If on a fixed dose of insulin, can individual inject insulin with a pre-filled syringe; or if on sliding scale, can applicant draw up and inject insulin?

- A. Applicant is **always able** to inject a fixed dose of insulin with a pre-filled syringe; or, if on a sliding scale, is able to draw up and self inject insulin.
- U. Applicant **requires physical assistance 1-3 days per week** to inject a fixed dose of insulin with a pre-filled syringe; OR, if on a sliding scale, requires physical assistance 1-3 days per week to draw up and/or inject insulin.
- UN. Applicant **requires physical assistance 4 or more days per week** to inject a fixed dose of insulin with a pre-filled syringe; OR, if on a sliding scale, requires physical assistance 4 or more days per week to draw up and/or inject insulin.
- N. Applicant **requires physical assistance** with insulin administration **on a daily basis**.

NOTE: If 'UN' or 'N' is marked, please provide explanation regarding why applicant is unable to inject insulin with a pre-filled syringe or draw up and inject sliding scale insulin. _____

VIII. BEHAVIOR

Does applicant require continual staff intervention for a persistent pattern of dementia-related behavioral problems (i.e., aggressive physical behavior, disrobing, or repetitive elopement)?

- A. Applicant **persistently requires staff/caregiver intervention on a daily basis** due to an established and persistent pattern of dementia related behavioral problems.
- U. Applicant **persistently requires staff/caregiver intervention 4 or more days per week** due to an established and persistent pattern of dementia related behavioral problems.
- UN. Applicant **persistently requires staff/caregiver intervention 1-3 days per week** due to an established and persistent pattern of dementia related behavioral problems.
- N. Applicant **does not have** a persistent pattern of dementia related behavior problems requiring staff/caregiver intervention.

NOTE: If 'A' or 'U' is marked, please specify the behavioral problems requiring continual staff or caregiver intervention. _____

NOTE: This page is for LEVEL 2 Nursing Facility Services ONLY:

SKILLED NURSING & REHABILITATIVE SERVICES (Check all that apply and indicate frequency needed):

Reimbursement for Level 2 Nursing Facility Services requires specific supporting documentation for approval. The required supporting documentation is specified below *in italics* for *each* skilled or rehabilitative service. The specified documentation must be included with the PAE, whether submitted by fax, mail or in person. *TennCare does not provide reimbursement for rehabilitative services (see below) 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.

NEED	SERVICE	FREQUENCY	
		# of times Daily	# of times Weekly
<input type="checkbox"/>	Wound Care for Stage 3 or 4 decubitus <i>Physician's order and Wound Assessment (describing characteristics and measurements)</i>		
<input type="checkbox"/>	Other Wound Care (i.e., infected or dehisced wounds) <i>Physician's order and Wound Assessment (describing characteristics and measurements)</i>		
<input type="checkbox"/>	Injections, sliding scale insulin <i>Physician's order for Sliding Scale protocol and Blood Glucose Monitoring Log</i>		
<input type="checkbox"/>	Injections, other: IV, IM <i>Physician's Orders – Specify Frequency and Duration</i>		
<input type="checkbox"/>	Intravenous fluid administration <i>Physician's Orders – Specify Frequency and Duration</i>		
<input type="checkbox"/>	Isolation precautions <i>Lab report with organism and diagnosis to support isolation</i>		
<input type="checkbox"/>	*Occupational Therapy by OT or OT assistant <i>Physician's Orders and OT Evaluation – Specify Frequency, Duration, and Diagnosis</i>		
<input type="checkbox"/>	*Physical Therapy by PT or PT assistant <i>Physician's Orders and PT Evaluation – Specify Frequency, Duration, and Diagnosis</i>		
<input type="checkbox"/>	Teaching Catheter/Ostomy care <i>Skilling for <u>new</u> catheter/Ostomy only – Specify teaching plan</i>		
<input type="checkbox"/>	Teaching self-injection <i>Skilling for <u>new</u> diabetics only – Specify teaching plan</i>		
<input type="checkbox"/>	Total Parenteral nutrition <i>Physician's Orders</i>		
<input type="checkbox"/>	Tube feeding, enteral <i>Physician's Orders</i>		
<input type="checkbox"/>	Ventilator services <i>Physician's Orders</i>		
<input type="checkbox"/>	Peritoneal Dialysis <i>Physician's Orders</i>		
<input type="checkbox"/>	PCA Pump <i>Physician's Orders</i>		
<input type="checkbox"/>	New tracheostomy or old tracheostomy requiring frequent documented suctioning, multiple times per shift - <i>Physician's Orders, including date of tracheostomy and documentation of frequency of suctioning required, if applicable</i>		
<input type="checkbox"/>	Other <i>If other requests, submit supporting documentation.</i>		

CERTIFICATION OF ASSESSMENT

May be completed by a Physician, Nurse Practitioner, Physician Assistant, Registered or Licensed Nurse or Licensed Social Worker.

I certify that the level of care information provided in this PAE is accurate. I understand that this information will be used to determine the applicant's eligibility for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, 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.

Signature: _____ Credentials: _____ Date: _____

DIAGNOSES relevant to applicant's functional and/or skilled nursing needs: _____

REQUIRED ATTACHMENTS (In addition to the PAE, the following attachments **must** be submitted):

- √ A recent History and Physical (completed within 365 days of the PAE Request Date or date of Physician Certification below, whichever is earlier) OR other recent medical records supporting the applicant's functional and/or skilled nursing or rehabilitative needs signed by the physician, nurse practitioner or physician's assistant;
- √ Current Physician's Orders for the applicable Service Requested; and
- √ Supporting documentation for skilled nursing and/or rehabilitative services (if applicable) as specified on page 4.

PAE REQUEST DATE for Medicaid-reimbursed long-term care services: _____

CERTIFICATION of LEVEL OF CARE

I certify that the applicant requires the level of care provided in a nursing facility and that the requested long-term care services are medically necessary for this applicant. I understand that this information will be used to determine the applicant's eligibility for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, 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.

Signature of Physician: _____ Date: _____

COMPLETE THE SECTION BELOW ONLY IF THE PAE REQUEST DATE MUST BE REVISED

CERTIFICATION UPDATE

I certify that the applicant's medical condition on the revised PAE Request Date is consistent with that described in the initial certification and that Nursing Facility care is medically necessary for the applicant.

Revised PAE Request Date	Signature of Physician	Date of Signature