



Last Updated: 06/14/2022

Medicaid Long Term Services and Supports Screening in Nursing Facilities, Screening Restoration after COVID-19 Flexibilities

The purpose of this bulletin is to provide clarification and guidance related to required Medicaid Long Term Services and Supports (LTSS) Screening in Nursing Facilities.

The Code of Virginia 32.1-330 requires that all persons requesting or applying for Medicaid LTSS be screened prior to the initiation of services and 12VAC30-60-308 requires nursing facilities review the completed LTSS screening forms to ensure that applicable NF admission criteria have been met, documented, and submitted via the DMAS electronic screening record system **prior** to admission. During the COVID-19 public health emergency some individuals were admitted to nursing facilities directly from a hospital without a LTSS screening per allowance by Governors' Executive Orders (E.O. 58, 84, and 16). To assure that individuals are held harmless going forward, DMAS will allow 90 days from the date of this bulletin for conducting LTSS Screenings for any individual residing in a nursing facility without a LTSS Screening.

During the catchup time period, trained and certified nursing facility LTSS Screeners should complete a LTSS Screening for any individual who is or may be Medicaid eligible who resides in a nursing facility skilled, rehab, or long term care/intermediate care but does not have a valid, authorizing, LTSS Screening. All LTSS screenings must be conducted per regulation and DMAS established procedures as described in Chapter IV of the Medicaid LTSS Screening Manual, including screenings being signed and authorized by a physician and entered into the electronic Medicaid LTSS Screening (eMLS) system. All Medicaid-certified nursing facilities should also confirm that all individuals, regardless of payer status or services provision, have a Level I, and if needed, Level II Evaluation and Determination, Pre-Admission Screening (PAS) for Mental Illness (MI), Intellectual Disability (ID) or Related Conditions (RC).

Going forward, nursing facilities shall follow all laws and regulations regarding Medicaid LTSS Screening and PASRR for MI, ID and RC. All LTSS Screening teams must ensure that required LTSS Screenings are signed and authorized by a physician and entered into the electronic Medicaid LTSS Screening (eMLS) system. Nursing facilities must review each Medicaid LTSS Screening packet **PRIOR** to admission to ensure Medicaid nursing facility criteria has been met. This review must occur for all individuals already enrolled in Medicaid, those persons with pending Medicaid, and for persons anticipating initiating the Medicaid financial application process. A valid and correctly processed Medicaid LTSS Screening must exist for nursing facility enrollment payments to be made. The only exclusions are for those persons with Special Circumstances as allowed by 12VAC30-60-302.

Per federal law 42 CFR 483.100 through 138, all individuals being admitted to a Medicaid-certified nursing facility must have a Pre Admission Screening for MI, ID and RC, PRIOR to admission and regular resident reviews for all persons admitted with MI, ID or RC. This requirement is applicable to all persons regardless of financial status or reason for nursing facility admission. When a Hospital



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or Community LTSS Screening team is not required under 12VAC30-60-302. E to assess the individual for nursing facility level of care prior to admission to the nursing facility, it is the responsibility of the nursing facility to have a plan in place for assuring the completion of the Level I screening, and if needed, Level II evaluation and determination, conducted according to law, prior to nursing facility admission.

All LTSS Screening teams are reminded that they must provide a full copy of the Medicaid LTSS Screening to providers chosen by the individual. This includes the individual’s health plan, nursing facility, services facilitator or personal care agency, as well as the local Department of Social Services eligibility staff. Information on the copy of the LTSS Screening should not be altered and all information should be visible and not covered by stickers or otherwise obscured.

Training and guidance regarding Medicaid LTSS Screening and PAS for MI, ID and RC is available via DMAS. Questions and inquiries may sent to ScreeningAssistance@dmas.virginia.gov. LTSS Screeners are also invited to participate in monthly Screening Connection calls, held the second Tuesday of each month at 3:30 pm. Please contact ScreeningAssistance@dmas.virginia.gov to be placed on the notification distribution list.

PROVIDER CONTACT INFORMATION & RESOURCES

Virginia Medicaid Web Portal Automated Response System (ARS)

Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.

www.virginiamedicaid.dmas.virginia.gov

Medicall (Audio Response System)

Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.

1-800-884-9730 or 1-800-772-9996

KEPRO

Service authorization information for fee-for-service members.

<https://dmas.kepro.com/>

Provider Appeals

DMAS launched an appeals portal in 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal.

<https://www.dmas.virginia.gov/appeals/>



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Managed Care Programs

Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.

Medallion 4.0

<http://www.dmas.virginia.gov/#/med4>

CCC Plus

<http://www.dmas.virginia.gov/#/cccplus>

PACE

<http://www.dmas.virginia.gov/#/longtermprograms>

Magellan Behavioral Health

www.MagellanHealth.com/Provider

Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.

For credentialing and behavioral health service information, visit:

www.magellanofvirginia.com, email:

VAProviderQuestions@MagellanHealth.com, or

Call: 1-800-424-4046

Provider HELPLINE

Monday-Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.

1-804-786-6273

1-800-552-8627

Aetna Better Health of Virginia

www.aetnabetterhealth.com/Virginia

1-800-279-1878

Anthem HealthKeepers Plus

www.anthem.com/vamedicaid

1-800-901-0020

Molina Complete Care

1-800-424-4524 (CCC+)

1-800-424-4518 (M4)

Optima Family Care

1-800-881-2166 www.optimahealth.com/medicaid

United Healthcare

www.Uhcommunityplan.com/VA

and www.myuhc.com/communityplan

1-844-752-9434, TTY 711

Virginia Premier

1-800-727-7536 (TTY: 711), www.virginiapremier.com