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SUBCHAPTER Y	MEDICAL NECESSITY DETERMINATIONS
RULE §19.2401	**General Qualifications for Medical Necessity Determinations**

Medical necessity is the prerequisite for participation in the Medicaid (Title XIX) Long-term Care program. This section contains the general qualifications for a medical necessity determination. To verify that medical necessity exists, an individual must meet the conditions described in paragraphs (1) and (2) of this section.

(1) The individual must demonstrate a medical condition that:

(A) is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person; and

(B) requires licensed nurses' supervision, assessment, planning, and intervention that are available only in an institution.

(2) The individual must require medical or nursing services that:

(A) are ordered by a physician;

(B) are dependent upon the individual's documented medical conditions;

(C) require the skills of a registered or licensed vocational nurse;

(D) are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and

(E) are required on a regular basis.

Source Note: The provisions of this §19.2401 adopted to be effective September 1, 2008, 33 TexReg 7264

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SUBCHAPTER Y	MEDICAL NECESSITY DETERMINATIONS
RULE §19.2403	**Medical Necessity Determination**

(a) Purpose. A recipient must have a determination of medical necessity for nursing facility care to participate in the Texas Medicaid Nursing Facility Program.

(1) The state Medicaid claims administrator makes a medical necessity determination by evaluating a recipient's medical and nursing needs based on the MDS assessment required by DADS.

(2) A recipient must have a determination of medical necessity for nursing facility care before the nursing facility can be paid for services, except as provided in §19.2413 of this subchapter (relating to Determination of Payment Rate Based on the MDS Assessment Submission) and §19.2611 of this chapter (relating to Retroactive Vendor Payment).

(b) Admission MDS assessment review.

(1) The admission MDS assessment review process is initiated when the state Medicaid claims administrator receives an MDS assessment and the Long-Term Care Medicaid Information Section, in accordance with §19.2413 of this subchapter, indicating that a Medicaid applicant or recipient is requesting vendor payment for care in a contracted nursing facility. A registered nurse must sign and certify that the MDS assessment is completed in accordance with §19.801 of this chapter (relating to Resident Assessment).

(2) The admission MDS assessment review determines medical necessity and establishes the authorization for payment of a calculated RUG rate.

(c) Role of the state Medicaid claims administrator. The state Medicaid claims administrator reviews all MDS assessments, including significant change in status assessments, modifications, and significant corrections, and approves or denies medical necessity in accordance with §19.2401 of this subchapter (relating to General Qualifications for Medical Necessity Determinations).

(d) Effective period.

(1) A determination of medical necessity based on the admission MDS assessment review remains in effect for the time period determined by the federal MDS submission schedule.

(2) If a nursing facility submits a recipient's MDS assessment after the due date established by the federal MDS submission schedule, the recipient's medical necessity remains in effect for the period between the due date and the date the state Medicaid claims administrator received the MDS assessment.

(3) If a nursing facility submits a recipient's MDS assessment after the due date established by the federal

MDS submission schedule and, after reviewing the MDS assessment, the state Medicaid claims administrator determines that the recipient does not meet the criteria for medical necessity, the effective date of the denial of medical necessity is the date the state Medicaid claims administrator received the MDS assessment. A denial of medical necessity is conducted in accordance with §19.2407 of this subchapter (relating to Denied Medical Necessity).

(e) Permanent medical necessity.

(1) A recipient's permanent medical necessity status is established on the completion date of any MDS assessment approved for medical necessity no less than 184 calendar days after the recipient's admission to the Texas Medicaid Nursing Facility Program.

(2) A nursing facility must submit a recipient's MDS assessment in compliance with the federal MDS submission schedule even after the recipient achieves permanent medical necessity status.

(3) A recipient's permanent medical necessity status moves with the recipient, unless the recipient is discharged to home for more than 30 days.

(4) If a recipient who has permanent medical necessity status transfers to another Medicaid-certified nursing facility, the nursing facility to which the recipient transfers must complete a new MDS assessment in compliance with the federal MDS submission schedule.

(f) Insufficient information. If an MDS assessment does not have sufficient information for the state Medicaid claims administrator to make a medical necessity determination, the MDS assessment is put in suspense for 21 days with a message from the state Medicaid claims administrator informing the nursing facility that the MDS assessment has been put in suspense for 21 days. Unless the nursing facility provides sufficient information on the MDS assessment to determine medical necessity within 21 days, medical necessity is denied.

Source Note: The provisions of this §19.2403 adopted to be effective September 1, 2008, 33 TexReg 7264

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SUBCHAPTER Y	MEDICAL NECESSITY DETERMINATIONS
RULE §19.2405	**Physicians' Certifications and Recertifications**

The recipient's physician is required at intervals specified in §19.1210(b) of this title (relating to Certification and Recertification Requirements in Medicaid-Certified Facilities) to certify or recertify the necessity for continued nursing facility care.

Source Note: The provisions of this §19.2405 adopted to be effective May 1, 1995, 20 TexReg 2393.

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SUBCHAPTER Y	MEDICAL NECESSITY DETERMINATIONS
RULE §19.2407	**Denied Medical Necessity**

(a) If the state Medicaid claims administrator determines that a Medicaid applicant or a recipient does not meet the criteria for medical necessity described in §19.2401 of this subchapter (relating to General Qualifications for Medical Necessity Determinations), the state Medicaid claims administrator notifies the attending physician and the nursing facility in writing and provides them an opportunity to present additional information about the applicant's or recipient's medical need for nursing facility care.

(1) If the attending physician or a nursing facility physician does not respond or contest the findings of the state Medicaid claims administrator within 10 working days after receipt of the written notice about the decision, the findings are final.

(2) If the attending physician or a nursing facility physician contests the findings of the state Medicaid claims administrator, at least one physician with the state Medicaid claims administrator must review the case. If the state Medicaid claims administrator's physician determines that the applicant's or recipient's admission or stay is not medically necessary, the determination becomes final.

(3) The state Medicaid claims administrator sends written notification of the final determination of denied medical necessity to the attending physician, the nursing facility, and the applicant or recipient (or responsible party).

(b) After an applicant receives written notice of a determination of denied medical necessity, the applicant or responsible party must request a fair hearing within 90 days after the date of denied medical necessity, or the applicant loses the right to a fair hearing.

(c) After a recipient receives written notice of a determination of denied medical necessity, the recipient or responsible party must request a fair hearing within 10 days after the date of the written notice in order to have nursing facility services paid for during the appeal.

(1) If the recipient requests a fair hearing within 10 days after the date of the written notice and the determination of denied medical necessity is upheld, the effective date of the denial is 10 days after the hearing officer's written decision.

(2) If the recipient does not request a fair hearing within 10 days after the date of the written notice, DADS makes vendor payments to the nursing facility at the previously established RUG rate for 15 days or until the recipient is discharged, whichever occurs first.

(3) If the recipient does not request a fair hearing within 10 days after the date of the written notice, the recipient must request a fair hearing within 90 days after the date of denied medical necessity, or the recipient

loses the right to a fair hearing.

(d) Fair hearings are conducted by the Texas Health and Human Services Commission (HHSC) in accordance with HHSC rules at 1 TAC Chapter 357.

Source Note: The provisions of this §19.2407 adopted to be effective September 1, 2008, 33 TexReg 7264

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SUBCHAPTER Y	MEDICAL NECESSITY DETERMINATIONS
RULE §19.2413	**Determination of Payment Rate Based on the MDS Assessment Submission**

(a) Definitions. In this section, the following words and terms have the following meanings unless the context clearly indicates otherwise.

(1) All conditions of eligibility--A recipient meets all conditions of eligibility when the state Medicaid claims administrator approves the recipient for medical necessity and the recipient meets financial eligibility for Medicaid.

(2) On-time MDS assessment--An MDS assessment that is submitted in accordance with the federal MDS submission schedule and is received by the state Medicaid claims administrator within 31 days after the completion date.

(3) Missed MDS assessment--An MDS assessment that is received by the state Medicaid claims administrator outside the time period that the MDS assessment covers.

(b) MDS submission requirement. A nursing facility must:

(1) complete all MDS assessments according to CMS' instructions;

(2) submit a recipient's MDS assessment, including an admission MDS assessment, a quarterly MDS assessment, and a significant change in status assessment, to the state MDS database in compliance with the federal MDS submission schedule;

(3) submit the Long-Term Care Medicaid Information Section to the state Medicaid claims administrator; and

(4) submit the recipient's MDS assessment in compliance with the federal MDS submission schedule even after the recipient has permanent medical necessity as described in §19.2403(e) of this subchapter (relating to Medical Necessity Determination).

(c) Admission MDS assessments.

(1) If a nursing facility discharges a recipient with a status of return not anticipated, and the recipient returns to the facility, the nursing facility must complete an admission MDS assessment for a determination of medical necessity and establishment of a RUG rate, regardless of the amount of time between the recipient's discharge and return.

(2) A nursing facility must complete and submit an admission MDS assessment to receive payment for a recipient's period of stay in the nursing facility, even if the recipient leaves the nursing facility before the MDS

assessment is completed and never returns long enough for the MDS assessment to be completed. See subsection (i) of this section for completion of an admission MDS assessment in the event of a recipient's death.

(3) DADS pays a calculated RUG rate for an admission MDS assessment from the date the recipient was admitted to the nursing facility, except as provided in §19.2611 of this chapter (relating to Retroactive Vendor Payments).

(d) Payment of a calculated RUG rate. If a recipient meets all conditions of eligibility, DADS pays a calculated RUG rate for an MDS assessment if it is received by the state Medicaid claims administrator during the time period that the MDS assessment covers.

(e) On-time MDS assessment. If a recipient meets all conditions of eligibility, DADS pays a calculated RUG rate from the completion date of the required MDS assessment, except for an admission MDS assessment as described in subsection (c)(3) of this section.

(f) MDS assessments that are not on time. The state Medicaid claims administrator stops payment for services if the state Medicaid claims administrator does not receive an on-time MDS assessment. Payment for services resumes when the state Medicaid claims administrator receives all MDS assessments that are due as required by the federal MDS submission schedule.

(g) Missed MDS assessments. When the state Medicaid claims administrator receives a missed MDS assessment, DADS pays the nursing facility a default RUG rate for the entire period of the missed MDS assessment if the recipient meets financial eligibility for Medicaid, except as provided in paragraph (2) of this subsection.

(1) If an MDS assessment is missed for the purpose of calculating a RUG rate, the nursing facility must still submit the MDS assessment to comply with §19.801 of this chapter (relating to Resident Assessment).

(2) For a newly contracted nursing facility and a nursing facility that undergoes a change of ownership, DADS pays the calculated RUG rate for any missed MDS assessments that occur while the nursing facility is unable to submit MDS assessments to the state MDS database.

(h) Significant change in status assessment, modification, or significant correction. If a recipient meets all conditions of eligibility, DADS pays the calculated RUG rate from the completion date of a significant change in status assessment, modification, or significant correction.

(i) Incomplete or erroneous MDS assessments. If an applicant meets all conditions of eligibility, DADS pays a default rate for an MDS assessment that is incomplete or has errors.

(j) Prohibition against recourse. A nursing facility must not charge and must not take any other recourse against a recipient, the recipient's family members, the recipient's estate or the recipient's representative for a claim that is reduced because the facility failed to comply with a DADS rule or procedure pertaining to reimbursement.

Source Note: The provisions of this §19.2413 adopted to be effective September 1, 2008, 33 TexReg 7264

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