

8.470 HOSPITAL BACK UP LEVEL OF CARE**8.470.1 DEFINITIONS**

Complex wound care means that the client meets the following criteria:

1. Has at least one of the following:
 - a. A complex surgical or traumatic wound;
 - b. Complicated wound graft surgery;
 - c. At least one stage IV pressure ulcer; or
 - d. A specialized wound-healing device, (e.g., Wound-Vac).
2. Requires a Medicare-rated group 2 or 3 pressure-relieving surface in order to heal.
3. Be receiving treatment for existing nutritional deficiencies.
4. Had any required debridement therapy initiated.
5. Had a consultation with a wound specialist and a resulting care plan has been initiated.

Medically complex means that a client meets the requirements of at least one of the following two subsections:

1. The client shall meet five of the seven following criteria:
 - a. Have difficulty communicating needs verbally, or require use of specialized adaptive equipment to communicate which requires set up by trained staff, or is unable to seek assistance through use of call light due to physical impairment;
 - b. Require on-site assessment by a physician once per week;
 - c. Require artificial nourishment via a gastro-intestinal tube (G-tube or NG-tube), and/or jejunostomy tube (J-tube);
 - d. Have a tracheotomy requiring suctioning, airway maintenance, or both at least every four hours;

- e. Require total parenteral nutrition (TPN) with or without lipids;
 - f. Require central line in active use for fluids and/or medications, excluding TPN;
 - g. Require skilled therapy, skilled nursing, or both for assessment, monitoring, and intervention at a greater frequency than is usually provided in a class I nursing facility.
2. The client shall meet all of the following criteria:
- a. Be a participant in the hospital back up level of care program immediately prior to qualifying under the criteria of **the first subsection of the definition of medically complex or any subsection of the ventilator-dependent definition**; and
 - b. Have difficulty communicating needs verbally, or require use of specialized adaptive equipment to communicate which requires set up by trained staff, or is unable to seek assistance through use of call light due to physical impairment; and
 - c. Require on-site assessment by a physician once every other week; and
 - d. Require artificial nourishment via a gastro-intestinal tube (G-tube or NG-tube), a jejunostomy tube (J-tube), or both; and
 - e. Have a tracheotomy requiring respiratory assessment, treatment or both at least every six hours; and
 - f. Require suctioning, assessment, and/or treatment by a skilled therapist or skilled nurse **with specialized training and demonstrated skill in respiratory therapy evaluation and treatment** as necessary in addition to the regular respiratory assessment, treatment, or both equating to a greater frequency than usually provided in a class I nursing facility.

Ventilator-dependent means that a client meets the requirements of at least one of the following **three** subsections:

- 1. If the client is actively weaning from the ventilator, the client shall:
 - a. Require intermittent ventilator support between two and 24 hours each day; and

- b. Require skilled nursing or respiratory therapy at least 12 hours each day in order to progress with weaning; and
 - c. Require physical therapy, occupational therapy and/or speech therapy five days per week; and
 - d. Have documented rehabilitation potential.
2. If active weaning fails, the client shall:
- a. Require continuous ventilator support between eight and 24 hours each day; and
 - b. Require respiratory therapy at least 3.5 hours each day in order to remain medically stable; and
 - c. Have one of the following scores on the ULTC 100.2 assessment form:
 - i) A score of at least two, in a minimum of two ADLs; or
 - ii) A score of at least two, in one category of supervision; and
 - d. Have difficulty communicating needs verbally, or require use of specialized adaptive equipment to communicate which requires set up by trained staff, or is unable to seek assistance through use of call light due to physical impairment.
3. If the client has been weaned off the ventilator and is actively weaning to reduce oxygen needs and/or remove the tracheotomy tube, the client shall:
- a. Have one of the following scores on the ULTC 100.2 assessment form:
 - i) A score of at least two, in a minimum of two ADLs; or
 - ii) A score of at least two, in one category of supervision; and
 - b. Have documented rehabilitation potential from a physician; and
 - c. Require the expertise of a respiratory therapist under the direction of a pulmonologist at least 3.5 hours each day in order to remain medically stable and/or show progression towards decannulation; and

- d. Require the expertise of a speech therapist to evaluate for a complete functioning swallow and/or require speech therapy treatment for strengthening of the oral muscles required to swallow properly; and
- e. Have minimal difficulty communicating needs and be able to follow simple commands.

8.470.2 CLIENT ELIGIBILITY

8.470.2.A. In order to be eligible for the hospital back up level of care, a client shall:

- 1. Meet long-term level of care requirements as determined by the appropriate Single Entry Point (SEP) agency;
- 2. Fall into one of the following categories:
 - a. Ventilator-dependent;
 - b. Complex wound care; or
 - c. Medically complex.
- 3. Be medically stable in a chronically acute state;
- 4. Be in the hospital prior to approval; and
- 5. Have a rate authorized by the Department. The rate shall be determined by the Department to exceed nursing facility's Class I reimbursement rate.

8.470.3 CLIENT ELIGIBILITY DETERMINATION

8.470.3.A. Upon referral from a hospital, the State Utilization Review Contractor (SURC) shall:

- 1. Conduct a review to determine whether the client meets the hospital back up level of care criteria and may be successfully treated in a nursing facility; and
- 2. Consider all other Medicaid programs and services and determine whether those programs would fail to meet the client's needs if the client were to be returned to the home.

8.470.3.B. When a hospital contacts a nursing facility regarding a potential client's eligibility for the hospital back up level of care, the nursing facility shall:

1. Assess the client on-site (in the hospital) to determine if the nursing facility can provide appropriate care.
2. Notify the SURC and the Department that it is considering admitting the client.
3. Prepare a care plan and submit it to the SURC.
4. Secure a transfer agreement with the discharging hospital in which the hospital agrees to readmit the client should care problems develop.

8.470.3.C. The care plan submitted to the SURC shall demonstrate that the nursing facility proposing to provide hospital back up level of care can meet the needs of the prospective client. The SURC shall review care plans to determine whether they meet pre-established professional standards of care.

8.470.3.D. The SURC shall review the medical documentation, the nursing facility care plan and the Single Entry Point (SEP) required documentation to determine whether or not the client meets the established hospital back up level of care criteria. The SURC may request any medical information and any other demographic information that the SURC deems necessary to make such determination. The SURC shall notify the Department in writing whether the client can be successfully treated in the nursing facility.

8.470.3.E. The SURC shall obtain a physician review for all clients who are considered to meet the hospital back up level of care criteria on initial evaluation. The physician's determination upon review shall be in writing and submitted to the SURC and the Department.

8.470.3.F. The SURC shall submit the care plan and supporting documentation to the Department with the written determination of approval or denial.

8.470.3.G. The SURC shall notify the client and the hospital, in writing, of the final determination. Notification to the client shall include recipient appeal rights as outlined in 10 C.C.R. 2505-10, Section 8.057.

8.470.4 INITIAL LENGTH OF STAY

8.470.4.A. Prior authorization for the initial length of stay of hospital back up nursing facility clients shall not exceed 90 days.

8.470.5 CONTINUED STAY REVIEW FOR HOSPITAL BACK UP LEVEL OF CARE NURSING FACILITY CLIENTS

8.470.5.A. The SURC shall conduct an on-site continued stay review for each hospital back up level nursing facility client 15 days prior to the end of the client's currently approved stay.

8.470.5.B. A continued stay review shall be conducted at least annually. The Department may request the SURC to conduct an unscheduled continued stay review at any time during the length of stay.

8.470.5.C. The continued stay review shall determine whether:

1. The client continues to meet the hospital back up level of care criteria for hospital-level care in a nursing facility.
2. The client's care needs are adequately being met;
3. The approved care plan is being implemented;
4. Appropriate services are being provided; and
5. The care plan for the client should be adjusted to more appropriately meet the client's needs.

8.470.5.D. If the SURC determines, during the on-site continued stay review, that the client no longer meets the hospital back up level of care criteria:

1. A physician shall conduct an additional review to confirm the determination of the SURC.
2. If the physician review confirms that the client no longer meets the hospital back up level of care criteria, the SURC shall notify the client of the SURC's determination in writing. This letter shall include recipient appeal rights as outlined in 10 C.C.R. 2505-10, Section 8.057.
3. The SURC shall notify the Department in writing if both the physician review and the SURC determine the client no longer meets the hospital back up level of care criteria and shall include the supporting documentation.
4. The Department shall notify the client and/or the client's legal representative, the nursing facility currently providing the hospital back up level of care and the treating primary care physician that the SURC and the physician reviewer have determined that the client no longer meets hospital back up level of care criteria and that within 60 days the rate shall be reduced to the nursing facility's class I rate. Within 15 days of the date on the notice the nursing facility providing the hospital back up level of care shall notify the Department in writing whether it will provide care for the client at its standard class I rate.
 - a. In circumstances in which the nursing facility chooses to transfer or discharge a client who ceases to meet the hospital back up level of care criteria, the nursing facility shall comply with notification requirements of 10 C.C.R. 2505-10, Section 8.057.1.D. and Section

8.057.1.E, including notification of the client's right to appeal the transfer or discharge.

- b. The discharging nursing facility shall adhere to the Colorado Department of Public Health and Environment (CDPHE) rules specific to client discharge or transfer as outlined in 6 C.C.R. 1011-1, Chapter V, Section 12.6.
5. The receiving class I nursing facility shall prepare a care plan and submit it to the SURC. The care plan submitted to the SURC shall demonstrate that the receiving class I nursing facility can meet the needs of the prospective client. The SURC shall review care plans to determine whether they meet pre-established professional standards of care.
6. The Department shall notify CDPHE at the time of the transfer from the hospital back up level of care the name of the client being transferred and the name of the receiving class I nursing facility.

8.470.6 NURSING FACILITY QUALIFICATION FOR HOSPITAL BACK UP LEVEL

8.470.6.A. In order to participate as a hospital back up level nursing facility, the nursing facility shall submit an application to the Department that demonstrates:

1. The nursing facility is Medicaid certified and licensed to provide skilled care;
2. Financial stability for corporate and individual nursing facility;
3. Availability of skilled nursing services 24 hours per day;
4. Staff stability;
5. History of survey compliance;
6. Compliance with the direct client care regulations "Chapter II – General Licensure Standards" and "Chapter V – Long Term Care Facilities" administered by the Colorado Department of Public Health and Environment (CDPHE); and
7. A recommendation from CDPHE for the nursing facility to participate in the hospital back up level of care program.

8.470.6.B. The Department may request evidence of financial stability and survey compliance periodically throughout the nursing facility's participation.

8.470.6.C. If the nursing facility has applied to admit ventilator-dependent clients, the nursing facility shall meet the following additional requirements:

1. Maintain staff dedicated to the ventilator unit 24 hours a day, seven days a week;
2. Have a generator that is capable of providing heating, cooling and continuous electricity for needed equipment in the event of power outages;
3. Maintain staff that has experience and current training in the care of ventilator dependent clients;
4. Have a wound care consultant available as needed; and
5. Maintain 24 hour on-site coverage by a respiratory therapist.

8.470.6.D. If the nursing facility has applied to admit wound care clients, the nursing facility shall meet the following additional requirements:

1. Have a wound care specialist nurse or nurses capable of providing the wound care required by the wound care clients on a 24 hour basis; and
2. Have access to specialized wound care equipment necessary to meet the needs of the wound care clients.

8.470.6.E. If the nursing facility has applied to admit medically complex clients, the nursing facility shall meet the following additional requirements:

1. Maintain sufficient skilled nursing staff experienced in and trained in the care of medically complex clients;
2. Have 24 hour on-site coverage by a respiratory therapist or therapists to meet the assessed respiratory therapy needs of each medically complex client;
3. Have access to respiratory equipment necessary to meet the assessed needs of each medically complex client;
4. Have a wound care consultant available as needed; and
5. Provide physician support necessary for onsite monitoring of medically complex clients at least one time per week.

8.470.6.F. A nursing facility participating in the hospital back up level of care program shall:

1. Use the forms approved by the Department to document the care of hospital back up level of care clients.
2. Evaluate all clients upon admission, whenever there is a change in the client's condition and annually.

3. Notify the Department of a client's change of condition, discharge or death.

8.470.6.G. The Department may deny a nursing facility's request to participate as a hospital back up level of care nursing facility if the nursing facility does not meet all of the criteria for participation.

8.470.6.H. The Department may revoke a nursing facility's authorization to participate in the hospital back up level of care program if the nursing facility is not in compliance with the criteria.

8.470.7 REIMBURSEMENT OF NURSING FACILITIES SERVING HOSPITAL BACK UP LEVEL OF CARE CLIENTS

8.470.7.A. The Medicaid reimbursement for services provided to a hospital-back up level of care nursing facility client shall be negotiated between the Department and nursing facility in accordance with this subsection.

1. The Medicaid reimbursement for each client shall correspond to the negotiated cost of the services, durable medical equipment, and supplies as identified in the client's SURC approved care plan.
2. The Medicaid reimbursement for a hospital back up level of care client shall not be based upon or related to the audited, cost-based reimbursement for a nursing facility's class I nursing facility residents. The appeal rights and procedures applicable to the Department's determination of a nursing facility's class I rate shall not apply to the reimbursement offered or paid by the Department for a hospital back up level of care client.
3. The Department and nursing facility shall negotiate the Medicaid reimbursement for an approved hospital back up level of care client, at the time of initial placement in the nursing facility and whenever there is a significant change in the client's approved care plan or other relevant circumstances.
4. In the event that the Department and nursing facility are unable to reach agreement on an appropriate level of Medicaid reimbursement for a hospital back up level of care client, arrangements shall be made for the discharge of the client to another appropriate placement. The Department shall continue to reimburse the nursing facility for the client's care at the most recently agreed level of reimbursement until the nursing facility can provide appropriate placement, not to exceed 60 days.

5. Under no circumstances shall the payment for a hospital back up level of care client exceed 90 percent of the Medicaid payment to the discharging hospital.
6. If the Department determines that the client's third party coverage (private insurance or Medicare) will cover the cost of the client's care in either a hospital or nursing facility, Medicaid payment under this program shall be approved only after utilization of third party benefits.

8.470.7.B. Drugs and oxygen shall be billed directly to Medicaid by providers.

8.470.8 REPORTING ON MED-13

8.470.8.A. The Medicaid reimbursement for hospital back up level of care clients (hereafter referred to in this paragraph as "hospital-level reimbursement") shall not impact the Medicaid per diem cost and rate set for the nursing facility's class I Medicaid clients based on the MED-13 cost reporting process. The hospital-level reimbursement shall be reported on the MED-13 cost report form in the following manner so that it does not impact the class I Medicaid per diem rate established by the cost report:

1. The hospital-level reimbursement shall be included on the appropriate line in columns 1-8 on Schedule C.
2. Offset of the hospital-level reimbursement shall be made on Schedule B with a detailed supplemental schedule attached.