DMS Level of Care Transformation – FAQs

General

1. Why is the Department for Medicaid Services (DMS) changing some of its level of care (LOC) policies and processes for nursing facility, hospice, and intermediate care facility for individuals with intellectual disabilities (ICF-IID) services?

   DMS is beginning a LOC transformation project that will transition paper-based LOC processes to a new electronic self-service portal: the Kentucky Level of Care System (KLOCS). These policy and process changes will enable the transition to KLOCS. Similarly, KLOCS will make some of the existing processes unnecessary, and therefore, DMS is changing its policies to reflect new automation by KLOCS.

2. Which providers are impacted by the changes to LOC policies and processes?

   Nursing facilities (provider type 12), hospice (provider type 44) and ICF-IID (provider type 11) are the three providers that are impacted by these changes. Two additional stakeholders, Community Mental Health Centers (CMHC), who are responsible for conducting the Preadmission Screening and Resident Review (PASRR) Level II evaluations for nursing facility residents, and the Peer Review Organization (PRO), who makes LOC determinations and conducts reassessments, will be impacted by some of these changes.

3. When will these changes happen?

   The anticipated effective date for these changes is 12/04/2017.

Kentucky Level of Care System (KLOCS) Implementation

4. What is KLOCS and when will it be implemented?

   KLOCS is the new electronic self-service portal that will replace paper-based processes for determining an individual's LOC for nursing facility, ICF-IID, and hospice services. KLOCS will be the only way for nursing facility, ICF-IID, and hospice providers to request an LOC for an individual. The anticipated implementation date of KLOCS is 11/30/2017, and providers will have access on 12/4/2017.

5. Do providers need to submit LOC requests in KLOCS, as well as faxing this information?

   No. Once KLOCS is implemented, the provider does not need to fax any information to DMS or the PRO.

6. What is being done to prepare providers for these changes?

   DMS will be hosting training forums across the state for provider staff who will be working with KLOCS as part of their day-to-day responsibilities beginning in mid-October and continuing through November. The schedule of these trainings will be shared with providers as soon as it is finalized. We are also developing a web-based training, job aids, and system manuals that providers can reference for additional support.

7. When will providers gain information about how to access the system?

   Providers will receive information about how to access the system during trainings. Providers will have access to the system on 12/04/17.

8. Are there any restrictions on the number of people who can have access to KLOCS from one provider?

   At this time, there is no maximum number of users from each provider. Ideally, every staff member who will be using KLOCS should receive access and attend the training forums.

9. How will errors be corrected and will these errors impact provider payment?

   The PRO will have the ability to correct errors. If there is an error, the provider should contact the PRO via email or phone. DMS does not anticipate errors to impact provider payment.

10. After the implementation of KLOCS, will providers need to reapply for LOC on the system for their existing patients?

    No. Existing LOC data will be transferred into KLOCS and providers will not need to resubmit their information.

11. What will happen to the MAP-24 and the MAP-4092 after KLOCS is implemented?

    The MAP-24 will be discontinued, as requests for admissions and discharges will be processed through KLOCS. The MAP-4092 will continue to be used. Providers should complete the MAP-4092 and upload it to KLOCS during the application process and the 30 day exempted hospital discharge will not change.

12. Will providers continue to receive lack of information requests via letters from the PRO?

    No, lack of information, or LOI, requests will be communicated via a task in KLOCS which will prompt the provider to give the missing information to the PRO for review.

13. If a provider has multiple staff with access to KLOCS, will a task for lack of information only be sent to the staff member who started the individual's initial application?

    No. The tasks in KLOCS are group tasks, meaning that all of the provider's users will be notified of the task and any of them can take action on the task, even if they did not initiate the application for the individual.

14. If one staff member from the provider begins an individual's application on KLOCS, then saves and exits, can a different staff member continue the application?

    Yes.

15. How will DCBS be notified that there is a change in an individual's LOC?

DCBS has access to Worker Portal in benefind, and KLOCS will sync with benefind, allowing DCBS to be aware of an individual's LOC status.

16. How should providers use KLOCS to admit individuals who currently have private insurance who may become Medicaid eligible in the future?

    If an individual may become Medicaid eligible in the future, providers should use KLOCS to submit the initial LOC application for the individual during their admission. As soon as the individual applies for Medicaid via benefind and is deemed eligible, benefind will match the individual's LOC with their Medicaid case, allowing a seamless transition for the individual.

17. Will there be any type of confirmation of submission of the LOC that providers will be able to print?

    Yes. After the application is submitted there is an option to print the completed application and there is a confirmation screen with the application number that can be printed for tracking. Additionally, the provider will be able to see the application status for each pending application on KLOCS for their organization only.

18. How does KLOCS and new processes affect the prior authorization notification process?

    The LOC will act as the prior authorization for nursing facility, ICF-IID, and hospice services. For ancillary services, prior authorization notices will be delivered in the same way as they currently are. Notification that an LOC has been met for nursing facility, ICF-IID, or hospice services will be in the provider's message center in KLOCS.

19. Is the timeline for submitting applications for ancillary services and therapies changing?

    The LOC transformation project does not impact any processes for ancillary services and therapies.

20. How does KLOCS impact Medicaid eligibility determinations and the process for these determinations?

    KLOCS will only handle level of care determinations, but it will sync with benefind to associate an individual's LOC status with their Medicaid, if the individual has already applied and been deemed eligible for Medicaid. The process for applying for Medicaid will not change.

21. If a PASRR Level II resident goes to the hospital and has a significant change in status, will the nursing facility continue to submit a paper MAP-4095, or will the nursing facility do something online for these?

    Significant changes will be processed through KLOCS, and the MAP-4095 will be eliminated. If the nursing facility needs to request a new PASRR Level II for the individual due to a significant change, they will request a PASRR Level II evaluation through KLOCS and select significant change as the reason for the request.

22. If a resident did not trigger a PASRR Level II upon admission, but then begins psych services, do providers use the system to contact the CMHC for a PASRR Level II referral? If so, how?

    The nursing facility will use KLOCS to request a PASRR Level II for the individual, and the CMHC will be notified by KLOCS to complete the evaluation. The provider will not have to contact the CMHC directly.

23. If weekend admissions are expected, is it possible to complete information and save it and then the weekend supervisor can then send it?

    Yes. The nursing facility provider will be able to save and return to the LOC application once they have completed the first section of the PASRR Level I.

24. What will happen to the MAP-378 Termination of Hospice Benefits form?

    The MAP-378 will be eliminated and all terminations of hospice benefits will be processed through KLOCS.

25. Will providers receive emails notifying that they have a message on KLOCS?

    No. All KLOCS users will need to log into KLOCS to check their messages and tasks.

26. Will providers continue to receive paper confirmations that the LOC is met?

    No. These correspondences will happen through KLOCS, so providers will be notified in their message center that an individual's LOC is met.

27. SNF currently receives a Confirmation Notice and a Prior Authorization Letter before the MAP-552 is issued for new admissions. Will both letters be generated in KLOCS?

    The LOC will serve as the prior authorization for nursing facility services. The nursing facility will be notified in their message center in KLOCS that the individual's LOC has been met, and they will no longer receive paper correspondences.

28. Will individuals with an MCO need to complete an LOC application?

    If an individual with an MCO resides in a facility, they will not need an LOC since they are only residing in a facility for a short period of time. When/if the individual becomes a resident in your facility for long-term care, a full LOC application will need to be completed with an updated date of admission.

29. If an individual is admitted after normal business hours, or on a weekend or holiday, should the LOC application be submitted on the same day or prior to admission?

    KLOCS is available 24/7 to process LOC applications. The start date of the LOC will be the date that the LOC application is submitted, unless the provider is submitting the

application prior to admission, which would make the start date of the LOC whichever date in the future the provider noted would be the admission of the individual. If the provider admitted an individual before submitting the LOC application due to emergency circumstances, then they will enter a past date as the expected admission date on the PASRR Level I. The PRO will need to override KLOCS to approve the backdated LOC start date.

30. What should the provider do if they have to make changes to the LOC request after the original submission?

    The provider should contact the PRO by phone or email to make changes to the LOC request after it has been submitted.

31. The PASRR Level I and the MAP-726A will be screens in KLOCS and providers will complete these electronically. Is the PASRR Level II also being made into a screen in KLOCS?

    No. The PASRR Level II will remain a paper form, which will be completed by the CMHC, and will be uploaded into KLOCS.

Nursing Facility LOC Application

32. What are the changes to the nursing facility LOC application process?

    Nursing facilities are still required to submit both the PASRR Level I, formerly known as the MAP-409, and the MAP-726A to request LOC for an individual. However, the timeline for completing the MAP-726A is expedited: the MAP-726A must be completed in KLOCS at the same time as the PASRR Level I, and the LOC start date cannot begin until the MAP-726A has been received. The MAP-726A has been changed and is now easier to complete. Providers will **no longer** have up to 7 days after admission to submit the MAP-726A.

33. What are the primary changes to the MAP-726A?

    The MAP-726A no longer requires the signature of a clinician and the form has been simplified with fewer required elements. Many of the current elements on the MAP-726A will no longer be needed because KLOCS will already have captured the information. Additionally, the MAP-726A will no longer be submitted by nursing facilities for individuals who are requesting institutionalized hospice services.

34. What is the timeframe for the submission of the MAP-726A? Does the entire form need to be completed in order to submit?

    The MAP-726A needs to be completed before the individual is admitted to the nursing facility. The LOC will begin on the date of submission and Medicaid reimbursements will be dated to the date of submission, unless the date of admission listed on the MAP-726A is a date in the future. If the provider submits the application in KLOCS in advance of the admission, then the LOC start date will be the date indicated on the MAP-726A. Most of the fields on the MAP-726A need to have an input for the application to be submitted, and KLOCS will not let you submit the application unless all required fields have been completed.

35. What if the nursing facility does not have detailed information about the individual's status at the time of admission (nutrition status, skin condition, etc.)?

    Many of the fields on the MAP-726A related to the individual's status and condition are not mandatory, and therefore, if the nursing facility does not think they have the complete information about the individual, they can skip the category. However, this may result in the PRO determining that the LOC status is pending due to lack of information, which will allow the necessary time to gather the required information.

36. Can the MAP-726A still be completed upon payor change and not necessarily the admission date?

    Yes. Ideally, the provider should submit a LOC through KLOCS upon admission, but if they do not, they can submit the LOC application when there is a payor change. Note: the provider cannot be paid by Medicaid for services provided until the LOC application has been submitted.

37. Will providers be able to print off the MAP-726A to gather information prior to inputting the information on the computer?

    No. Once an application is completed, the provider can print the individual's full application, including the PASRR Level I and the MAP-726A, but a blank application cannot be printed.

38. When do the new PASRR Level I and MAP-726A take effect?

    They take effect on 12/04/17, when KLOCS is implemented.

39. How many days before admission to a nursing facility can the MAP-350 be filed?

    The MAP-350 can be completed and uploaded into KLOCS as soon as the provider starts the application for the individual. A provider can start an application for an individual any time in advance of admission.

40. Does the MAP-350 need to be submitted on the date of admission?

    The MAP-350 is part of the nursing facility LOC application and therefore, must be completed and uploaded before the provider can submit the LOC application.

41. Since the MAP-350 is required annually, will the nursing facility also have to upload the MAP-350 into KLOCS each year?

    Yes, the new MAP-350 should be completed and uploaded each year into KLOCS.

42. What happens if an individual is considering two nursing facilities and both try to apply for LOCs for the individual?

    The facility which completed the application in KLOCS first will be able to submit the application for LOC determination, while the second facility will receive an error message and

be prevented from submitting their application, as it would cause overlapping LOCs. If the individual chooses to be admitted to the second facility, then the first facility would have to submit a discharge for the individual for the same date as the date of admission on the LOC application. Then, the second facility would submit their application with an admission date for the next day. One of the facilities would then need to contact the PRO to have the dates adjusted.

43. In the scenario when an individual is choosing a different nursing facility after the first nursing facility has already submitted an LOC application, how long is the second nursing facility going to have to wait before they can submit an application for the individual? Will they have to wait a few days while the PRO corrects the error or will they be able to submit the MAP-726A?

    The second provider can contact the PRO to inform them about the individual's intention to reside in their facility and request the PRO to mark the LOC application by the first provider as "Not Met".

44. How will the admissions process work for individuals who are being readmitted from the hospital?

    If the individual was admitted to the hospital for less than 14 days on a bed hold, then they do not need to be readmitted to the nursing facility because that individual should not have been discharged from the nursing facility. If the individual was discharged from the nursing facility and admitted to the hospital, a new application will need to be submitted and their LOC will need to be re-determined. The provider will not need to complete a PASRR Level I as part of the application since their previous PASRR Level I is still valid, but they will need to complete the MAP-726A.

45. How will individuals being readmitted after the expiration of their bed hold days be handled?

    If the individual has not been in the nursing facility for greater than 14 days, Medicaid will no longer pay to hold the bed, so the nursing facility must decide if they are going to discharge the individual. If the individual is discharged from the nursing facility and then is requesting readmission, the provider will need to submit a new application for the individual, but will only need to complete the MAP-726A since the PASRR Level I will still be valid, as long as the individual was discharged to equal or greater level of care.

46. Will hospital discharge staff need to utilize KLOCS for placement or will nursing facilities continue to complete this information?

    It is the responsibility of the nursing facility provider to complete all required information in KLOCS for admissions and discharges.

47. We are a ventilator dependent skilled nursing facility. Where will we indicate the ventilator settings on the new form?

    There is a small ventilator sub-section on the MAP-726A where you will note the hours per day on the ventilator and the ventilator settings.

48. What if an individual goes to the hospital on a bed hold and comes back needing a different level of care? Will we still do a new LOC online like we do now? Do we discharge them in KLOCS on readmit and then put the new date of service when cut from skilled?

    If an individual goes to the hospital on a bed hold, and returns to the nursing facility but needs to request a different level of care than the level of care for which they were initially admitted to the nursing facility, the nursing facility will need to discharge the individual to end their existing LOC. Then, the nursing facility should submit a new application for the individual reflecting the new level of care that they are requesting on the MAP-726A. The provider will not need to complete a new PASRR Level I for the individual.

49. We are critical access and at present are not required to complete a PASRR Level I, will this change?

    When a provider starts an application for an individual's LOC, there is an option in KLOCS to select that the provider is a swing bed facility. This will allow the swing bed provider to skip the PASRR Level I. The swing bed provider will only need to complete the MAP-726A and upload the MAP-350 to submit the application. Swing bed providers are not required to complete a PASRR Level I.

50. Will the payment back date to admission date when a PASRR Level II is triggered?

    Yes. When a nursing facility admits an individual who requires a PASRR Level II, the provider will be paid for all days after the individual was admitted, as long as they submit the LOC application on or before the date of admission, and LOC is determined to be met.

51. If the individual has a Level II PASRR, can the nursing facility do notification of discharge/significant change/death in the system?

    Yes. All discharges, including death, and significant change requests, will be completed through KLOCS.

52. Since nursing facilities can do an LOC prior to admission and there is a 3 business day turnaround for a determination of LOC being met or not met for individuals who did not require a PASRR Level II, will nursing facilities have to wait for an approval before the patient is admitted to the facility?

    Medicaid will pay for nursing facility services provided to individuals who meet LOC as soon as the provider submits the LOC application and admits the individual. The LOC, if determined as Met, will be effective from the date of submission or the date of admission, whichever is later. If a nursing facility admits an individual and submits the LOC application at the time of admission, but it is determined by the PRO that the individual does not meet LOC, then the nursing facility will not be paid for the services provided to that individual.

53. On the MAP-350, all of the admission paperwork is electronically signed. Will that be okay or do we have to get actual signature?

Electronic signatures will be accepted on the MAP-350, but regardless of the signature mechanism, the MAP-350 must be uploaded into KLOCS.

54. For individuals who are unable to sign the MAP-350, will verbal accepts from the individual or family continue to be accepted?

    Yes, as long as the nursing facility staff verifies this on the MAP-350 (date and witness signature).

55. Is a copy of the PASRR Level I required to be in the chart?

    DMS will not require a paper copy to be in the chart.

56. If there is an immediate need to move a patient from a personal care to a nursing facility and a PASRR Level II is required, how should we proceed to move the patient and receive payment when they are Medicaid only?

    The provider should move the patient to the nursing facility and complete the LOC application in KLOCS on the day the individual is moved. If a PASRR Level II is required, a task is sent to the CMHC to complete the evaluation, but the provider will be paid for the services provided after the individual is admitted and they submit the LOC application (PASRR Level I and MAP-726A), as long as LOC is determined to be met.

57. When would a nursing facility submit the MAP-726A if the resident is admitted into a non-certified bed but then moves to a Medicaid-certified bed?

    Ideally, the nursing facility should complete the LOC application upon admission of the individual to the nursing facility. However, if the nursing facility does not submit the LOC application when the individual is admitted, then the nursing facility will have to submit the full LOC application (PASRR Level I and MAP-726A) either before or on the day of the individual moving to a Medicaid certified bed.

58. Is a PASRR required for non-Medicaid individuals?

    Any individual who is requesting admission to a Medicaid-certified nursing facility, regardless of payor (private, Medicare, commercial), is required to undergo a PASRR Level I screen, which may trigger a PASRR Level II evaluation.

59. If they are Medicare/Managed Care and they go to a hospital overnight, that is a discharge but the nursing facility is expecting a return. Would we have to submit new PASRR/MAP726A forms for their readmission?

    If the provider has discharged the individual to hospital, and the provider had previously submitted an LOC (PASRR Level I and MAP-726A) in KLOCS, they will need to start a new application for LOC in KLOCS, but will only have to submit the MAP-726A since the PASRR Level I will still be valid.

60. If we have a Medicare resident for whom we are applying for Medicaid, and the individual discharges to the hospital for greater than 24 hours, is a new LOC and PASSR needed?

    If the provider discharges the individual in KLOCS, you will have to reapply for LOC. If the provider has discharged the individual to hospital, and the provider had previously submitted an LOC (PASRR Level I and MAP-726A) in KLOCS, they will need to start a new application for LOC in KLOCS, but will only have to submit the MAP-726A since the PASRR Level I will still be valid.

61. Per the MDS, payor source is not the determination to discharge; whether return is anticipated or not should determine if the individual should be discharged. If a person runs out of bed hold days, should they be discharged from the nursing facility?

    MDS requirements are not the same as LOC criteria and determinations. If the individual has run out of bed hold days, the nursing facility will need to decide whether or not to discharge the individual. If the individual is not likely to return to that nursing facility, or may request admission to a different nursing facility, then the nursing facility should discharge the individual.

62. If the bed hold days exhaust, but the family is paying privately to hold the bed, does the provider have to complete a new LOC when the individual returns to the nursing facility?

    If the nursing facility did not discharge the individual in KLOCS, then they would not need to complete a new LOC when the individual returns to the nursing facility.

63. Does the diagnosis have to be written out, or can the provider just list the ICD-10 code?

    Providers are required to identify at least one diagnosis of the individual. They will need to include the ICD-10 code, approximate date of onset, and select whether or not the diagnosis is primary or secondary. A description of the ICD-10 code is not required.

64. For individuals going to a psych stay, they cannot have a paid bed hold, and providers have been doing an unpaid bed hold, but not discharging the individual. Does their readmission require a new LOC?

    If the individual has not been discharged by the nursing facility, then they will not require a new LOC.

Nursing Facility Reassessments

65. What are the changes to the nursing facility LOC reassessment process?

    Individuals receiving services in a nursing facility will still need to be evaluated every 6 months by the PRO to determine if they continue to meet nursing facility LOC. However, some individuals will no longer need to undergo a 30-day field review. Currently, the PRO conducts field reviews on all individuals admitted to a nursing facility within 30 days of admission. DMS is changing its policy and will no longer require individuals who have been evaluated with a PASRR Level II by the CMHC to undergo a 30-day field review by the PRO. The reason for this change is that the CMHC has already confirmed the individual's LOC status with the PASRR Level II evaluation, and therefore, the PRO field review is duplicative. Therefore, the PRO

will only conduct 30-day field reviews for those individuals who did not require a PASRR Level II evaluation.

Hospice LOC Application

66. What are the changes to the hospice LOC application process?

    Hospice providers are still required to submit the MAP-374 and the physician statement to request LOC for an individual. However, hospice providers will no longer submit their LOC applications to the Department for Community Based Services (DCBS). Additionally, the hospice LOC application will undergo a clinical review to determine if hospice level of care is appropriate for the individual.

    Hospice providers should submit the LOC application prior to or on the day of the individual beginning to receive hospice services.

67. Who will conduct the clinical review to determine if hospice LOC is met?

    There are three entities that will be responsible for determining if the individual's application meets the criteria for hospice LOC: PRO, CMHC, and the Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID). The responsible entity varies based on the specific scenario of the individual:

    - For all individuals requesting non-institutionalized hospice, the PRO will determine if LOC is met.
    - For individuals requesting institutionalized hospice, and who already have a previously completed PASRR on file in KLOCS, the PRO will determine if LOC is met.
    - For individuals requesting institutionalized hospice, and who do not need a PASRR Level II evaluation, the PRO will determine if LOC is met.
    - For individuals requesting institutionalized hospice, and who require a PASRR Level II evaluation for a mental illness, the CMHC will determine if LOC is met.
    - For individuals requesting institutionalized hospice, and who require a PASRR Level II for an intellectual disability or dual diagnosis, DBHDID will determine if LOC is met.

68. How does the LOC application process differ between institutionalized and non-institutionalized hospice?

    The information required to be submitted by the hospice provider when requesting LOC for either institutionalized or non-institutionalized hospice is the same: the MAP-374 and the MAP-377 which includes the physician statement are required for both. For institutionalized hospice, the hospice provider must also identify in KLOCS the nursing facility where the individual will reside when they are submitting the LOC application. The reason for this is because the nursing facility is responsible for completing a PASRR for individuals requesting institutionalized hospice.

69. What form(s) does the nursing facility provider have to complete for an individual requesting institutionalized hospice services?

Every individual who will be residing in a nursing facility must be evaluated with a PASRR Level I, including when the individual is receiving hospice in a nursing facility. When the hospice provider submits the LOC application for institutionalized hospice, they will be prompted to identify the nursing facility where the individual will be residing.

KLOCS will automatically check to see if a PASRR Level I has already been completed and exists for that individual on the system. If a PASRR Level I exists on KLOCS for the individual and is still valid, even if it was completed by another nursing facility, the nursing facility will not need to complete another one and the nursing facility does not need to do anything for the institutionalized hospice request. KLOCS will associate the individual's PASRR Level I information to the nursing facility. However, if a PASRR Level I does not exist on KLOCS for the individual, the system will automatically send a task to the nursing facility to prompt them to complete the PASRR Level I for the individual.

70. If an institutionalized hospice resident no longer needs hospice services, or decides to discontinue hospice services, but still resides in the nursing facility, what needs to be done?

    The hospice provider needs to discharge the individual. Assuming the individual already has a completed PASRR Level I on file, the nursing facility will need to initiate a new LOC application for the individual, but will only be required to submit the MAP-726A, since the PASRR Level I will still be valid.

71. Should the nursing facility provider initiate a LOC application request for an individual who will be receiving hospice in their facility?

    No. Only the hospice provider should submit a LOC application for an individual requesting institutionalized hospice. The hospice provider will identify the nursing facility where the individual is residing, and this will allow the nursing facility to be notified if they need to submit additional information to complete the institutionalized hospice LOC application.

    Currently, the nursing facility submits a PASRR Level I and the MAP-726A for an individual who is requesting institutionalized hospice. DMS is changing this policy. The MAP-726A serves as the LOC application for those requesting a nursing facility LOC. The nursing facility provider should not submit a MAP-726A for individuals requesting institutionalized hospice because it would result in overlapping LOCs for both hospice and nursing facility services, which is not allowed. Specifically, an individual cannot have both a hospice LOC and a nursing facility LOC for the same timeframe. If an individual is planning to be discharged from hospice to a nursing facility or vice versa, they may submit an application for the new LOC while their current LOC is still active, as long as the timeframe in the request for the new LOC does not overlap with their current LOC.

72. Will nursing facilities be notified if an individual receiving hospice care in their facility is discharged?

    Yes, the nursing facility will receive a notification in KLOCS that the individual has been discharged from hospice. If the individual is going to be transitioning from hospice to nursing facility care, and staying in the same nursing facility, then the nursing facility should initiate a new application for the individual, which will require the nursing facility to complete the MAP-726A and upload a completed MAP-350 to request nursing facility LOC.

73. What if the individual has retroactive Medicaid after hospice admission that goes back to the admission date?

    If the individual's Medicaid is retroactive to their admission date to hospice, then the provider will be paid by Medicaid for services rendered beginning on the admission date.

74. Are there any situations where LOCs are allowed to overlap?

    There are two situations when an individual may have overlapping LOCs:

    - An individual has a Home and Community Based Services (HCBS) waiver LOC and a nursing facility LOC. This is allowed when the individual is going to be in the nursing facility for less than 60 days.
    - An individual has a HCBS waiver LOC and a non-institutionalized hospice LOC.

75. When an individual receiving Non-Institutionalized Hospice goes into an Institutionalized facility, will the MAP-403 still be required or will the LOC replace that?

    The MAP-403 will no longer be used. The hospice provider should discharge the individual from non-institutionalized hospice, and then submit a new LOC application for the individual for institutionalized hospice. Both of these actions will be completed through KLOCS.

Hospice Reassessments

76. What are the changes to the hospice LOC reassessment process?

    Hospice providers will be required to initiate reassessments for individuals by uploading a MAP-377 to KLOCS before the end of the current coverage period.

77. What are the coverage periods for hospice?

    When an individual is first determined to meet hospice LOC, their initial coverage period is 90 days. After the first 90 days, the hospice provider can initiate a reassessment and request an additional 90 days of coverage. After the second 90 days of coverage, coverage periods are for 60 days. This is a policy change: currently, the coverage periods after the second 90 days are for 30 days. DMS is changing its policy to align with the Medicare hospice reassessment timeline (90, 90, 60, 60, 60..).

78. What happens if the hospice provider does not submit the required reassessment documents?

    If the hospice provider fails to submit the physician's statement by the end of the coverage period, the individual will be automatically discharged after 30 calendar days.

79. If a new MAP-726A is submitted for a resident, does a new MAP-350 need to be signed as well?

If the original MAP 350 was signed within the last year, a new one does not need to be completed and uploaded with the new MAP-726A, as the current MAP-350 is still valid.

ICF-IID LOC Application

80. What are the changes to the LOC process for ICF-IID providers?

    ICF-IID providers will now request an LOC for an individual by completing and submitting the MAP-726A. The MAP-726A collects information about the individual's status and needs, including how the individual breathes, eats, and communicates. Using the MAP-726A ensures that consistent information is captured across all ICF-IID providers.

81. Currently, the ICF-IID provider calls and goes through a clinical review for the first 30 days of Medicaid certification. Will this continue?

    ICF-IID providers will no longer be able to call the PRO and provide clinical information over the phone to request LOC to authorize services for the individual. The ICF-IID provider will use KLOCS to complete the MAP-726A to request LOC for the individual, and then the PRO will make a determination if LOC is met. Then, the PRO will conduct an in-person review within the first 30 days of the individual's admission.

CMHC Requirements

82. Will there still be a Response to Referral (RTR)?

    No. There will no longer be a Response to Referral form. This will all exist within KLOCS.

83. Will the CMHCs still be required to complete the computer summary form?

    No. The implementation of KLOCS will make the computer summary form unnecessary. All of the information previously captured by the computer summary form will be captured in KLOCS.

84. How will an out-of-state nursing facility be able to request a PASRR Level II evaluation for an individual who is currently located in a Kentucky hospital?

    If the out-of-state nursing facility is not enrolled as a provider with Kentucky Medicaid, then the request for LOC should not be entered in KLOCS. The out-of-state nursing facility should follow the requirements of their state for requesting LOC. Since the individual requesting admission to an out-of-state nursing facility is currently located in Kentucky, one of the Kentucky CMHCs will be responsible for conducting the PASRR Level II evaluation. However, the CMHC should not use KLOCS to process this information, and should coordinate with the responsible entities in the state where the nursing facility is located to obtain the necessary information.