Nursing Home Transition Case Management Procedures for Transition Case Managers

1) Within 10 business days from receipt of referral from the ARC, the transition case manager will conduct a face-to-face visit to update the client’s initial DOEA-CARES Form 701B and complete the nursing home transition (NHT) plan. The transition case manager will document the start of transition case management services on the NHT plan.

2) Once barriers to transition are removed, and the transition case manager has determined the client is ready to safely return to the community, then the transition case manager and the client or designated representative must sign the NHT plan. The transition case manager will notify CARES (via the NHT plan) of the client’s estimated discharge date, and submit the updated 701B with the request for a level of care (LOC) via the DOEA-CARES Form 603.

3) The case management agency may bill for transition case management on the waiver start date. In order to bill, the following requirements must be met per the waiver handbooks:
   a. Client resided in nursing home 60 consecutive days by the time they discharged.
   b. No more than 20 hours of transition case management can be billed within 6 months of waiver start date.
   c. Client has a completed and signed NHT plan.
   d. Upon nursing home discharge, client is enrolled into the Aged and Disabled Adult Waiver (ADA) or Assisted Living for the Elderly Waiver (ALE).

4) Once the transition case manager has received the LOC, the transition case manager must submit Form 2515 to DCF and request ex parte.

5) Once DCF has provided the Notice of Case Action to the client and/or the transition case manager, the transition case manager must submit the Notice of Case Action to the ARC.

6) Within 14 business days of the waiver start date, the transition case manager must follow-up through face-to-face contact with the client to complete a 701B assessment in the community including completing the waiver care plan. This on-site follow-up should be completed as close to the waiver start date as necessary to ensure client’s care needs are met, and a safe transition to the community has occurred.

7) If the client is currently unable to transition after transition case management services have been provided, the transition case manager will finalize the NHT plan and forward it to CARES for due process notification. Both the transition case manager and the client or designated representative must sign the NHT plan.
   a. CARES will review the NHT plan from the transition case manager and complete a Notification of Decision Regarding Nursing Home Transition (DOEA Form 620). CARES will send the DOEA Form 620, as well as Medicaid fair hearing rights to any client that does not successfully transition.
b. In the case that a client is currently unable to transition out of the nursing home and into the ADA or ALE waiver, transition case management cannot be billed.

8) If client can transition without transition case management, then please follow the regular transition process by using approved AAA/ARC nursing home transition matrices.
Nursing Home Transition Case Management Procedures for Transition Case Managers

1. Transition case manager will receive referral from ARC. Within 10 business days of receipt, transition case manager updates client’s 701B & completes NHT plan (face-to-face visit).

2. Transition case manager notifies CARES of the estimated date of discharge using the NHT Plan & requests LOC.

3. ALL REQUIREMENTS MUST BE MET PER THE WAIVER HANDBOOKS IN ORDER TO BILL:
   A. Client resided in NH for 60 consecutive days by the time discharge occurs.
   B. No more than 20 hours of transition case management can be billed within 6 months of waiver start date.
   C. Client has a completed and signed nursing home transition (NHT) Plan.
   D. Upon nursing home discharge, client is enrolled in the ADA or ALE Waiver.

   [*NOTE: The first opportunity to bill is the waiver start date.*]

4. Upon receipt of waiver LOC, transition case manager submits Form 2515 to DCF & requests ex-parte.

5. The Notice of Case Action will be provided by DCF to the client & transition case manager will submit to the AAA/ARC.

   **YES**

   6. Within 14 business days, transition case manager must follow-up with a face-to-face client visit to complete 701B in the community to include completing the waiver care plan.

   **NO**

   7. Transition case manager finalizes NHT Plan documenting reasons why the client was unable transition & submits to CARES for due process notification (the NHT Plan MUST be signed even if client is unable to transition).

   CARES will review NHT Plan outcome, complete a Notification of Decision Regarding Nursing Home Transition (DOEA Form 620) and send to the client.

*DRAFT 01.11.11*

AAA = Area Agency on Aging
ARC = Aging Resource Center
ADA = Aged & Disabled Adult Waiver
ALE = Assisted Living for the Elderly Waiver
DCF = Department of Children & Families
DOEA = Department of Elder Affairs
ICP = Institutional Care Program
LOC = Level of Care
NH = Nursing Home
NHT = Nursing Home Transition
TCM = Transition Case Management