CHOICES Pre-Admission Evaluation (PAE)

APPLICANT Name (Last, First, Middle) _____ Date of Birth____/____/_____

Street Address _____ County _____

City _____ State _____ Zip _____

SSN _____-_____-_____ **AND** Medicaid Number (if currently eligible) _____

DESIGNEE Name (Last, First, Middle) _____

Street Address _____ Phone (_____)_____-_____

City _____ State _____ Zip _____

Applicant MUST identify the person that s/he wants to receive information about this application OR sign below to show that s/he chooses NOT to have anyone else receive this information:

☐ My signature certifies that I do NOT want a designated correspondent._____

SUBMITTING ENTITY Agency _____ Contact Name_____

(if other than admitting NF) Provider Number _____ Phone (_____)_____-_____ Fax (_____)_____-_____

SERVICE REQUESTED:

☐ **HCBS**

Check **Target Group(s)** below, as applicable:
☐ Age 65 + ☐ Physically disabled (21 +) – specify diagnosis or condition _____

Check **one** of the **Cost Neutrality Caps** below:
☐ Level 1 ☐ Level 2 ☐ CV (Chronic Ventilator) ☐ TS (Tracheal Suctioning)

Submission Request Type:
☐ New CHOICES Applicant ☐ Change in current LOC ☐ Current CHOICES member, current PAE ending
☐ CN Cap determination

Request Safety Determination: ☐ Yes ☐ No

☐ **Nursing Facility**

Check **one** of the **Reimbursement Levels** below:
☐ Level 1 ☐ Level 2 ☐ CV (Chronic Ventilator) ☐ TS (Tracheal Suctioning)

Submission Request Type:
☐ New CHOICES Applicant ☐ Change in current LOC ☐ Current CHOICES member, current PAE ending
☐ Hospice ***Hospice services are not LTC services. Do not submit PAE!**

Request Safety Determination: ☐ Yes ☐ No

Applicant Admitted From: ☐ Another NF ☐ Home ☐ Hospice Care ☐ Hospital

Applicant currently resides in a NF? ☐ Yes Date of NF admission____/____/_____ NF/SNF Medicaid Provider # _____
☐ No

Discharge Expectation: ☐ Discharge expected within 6 months ☐ Discharge not expected

Nursing Facility_____ Phone (_____)_____-_____

Address_____ City_____ State _____ County _____ Zip _____

Current NF payor source: ☐ Medicare ☐ Private Pay Requested date of Medicaid payment for NF services (**MOPD**)____/____/_____

NOTE: If applicant does NOT currently reside in a NF and/or Medicare is responsible for NF payment, applicant cannot be enrolled into CHOICES Group 1, even if a PAE is approved. Upon NF admission and/or exhaustion of Medicare benefit, the NF must via TPAES enter a Medicaid Only Payer Date (MOPD) before enrollment into CHOICES can occur.

I. TRANSFER:

The applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis**.**

*Approval of this deficit requires documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of transfer assistance required.

Can applicant transfer to and from bed, chair, or toilet without physical help from others?

A. Applicant is always capable of transfer to and from bed, chair, or toilet without physical assistance.
U. Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 1-3 days per week
UN. Applicant is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others 4-6 days per week.
N. Applicant is never capable of transfer to and from bed, chair, or toilet without physical assistance 7 days per week.

II. MOBILITY:

The applicant requires physical assistance from another person for mobility on an ongoing basis. Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair (manual or electric) if walking is not feasible.

*Approval of this deficit requires documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of mobility assistance required.

Can applicant walk without physical help from others?

A. Applicant is always capable of walking without physical assistance.
U. Applicant is incapable of walking unless physical assistance is provided by others 1-3 days per week.
UN. Applicant is incapable walking unless physical assistance is provided by others 4-6 days per week.
N. Applicant is never capable of walking without physical assistance 7 days per week.

If walking is not feasible (answer to mobility question above is UN or N), is applicant capable of using a wheelchair, either manual or electric?

A. Applicant is always capable of mobility without physical assistance.
U. Applicant is incapable of wheelchair mobility unless physical assistance is provided by others 1- 3 days per week.
UN. Applicant is incapable of wheelchair mobility unless physical assistance is provided by others 4-6 days per week.
N. Applicant is never capable of wheelchair mobility without physical assistance 7 days per week.

III. EATING:

The applicant requires physical assistance with gastrostomy tube feedings or physical assistance or constant one-on-one observation and verbal assistance (reminding, encouraging) to consume prepared food and drink (or self-administer tube feedings, as applicable) or must be fed part or all of each meal. Food preparation, tray set-up, assistance in cutting up foods, and general supervision of multiple residents shall not be considered to meet this requirement.

*Approval of this deficit requires documentation which supports the need for such intervention, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the applicant would be unable to self-perform this task. For PAEs submitted by an entity other than an MCO, NF, or PACE, an eating or feeding plan specifying the type, frequency and duration of supports required by the applicant for feeding, along with evidence that in the absence of such physical assistance or constant one-on-one observation and verbal assistance, the applicant would be unable to self-perform this task is required.

Can applicant eat prepared meals or administer tube feedings without assistance from others?

A. Applicant is always capable of eating prepared meals **or administering tube feedings** without assistance.
U. Applicant is incapable of eating prepared meals **or administering tube feedings** unless l assistance is provided by others 1-3 days per week.
UN. Applicant is incapable of eating prepared meals **or administering tube feedings** unless assistance is provided by others 4-6 days per week.
N. Applicant in never capable of eating prepared meals **or administering tube feedings** without assistance 7 days per week.

IV. TOILETING

The applicant requires physical assistance from another person to use the toilet on an ongoing basis
*Approval of this deficit requires documentation of the specific type and frequency of toileting assistance required.

Can applicant toilet without physical help from others (This does not include transferring)?

A. Applicant is always capable of toileting without physical assistance.
U. Applicant is incapable of toileting unless physical assistance is provided by others 1-3 days per week.
UN. Applicant is incapable of toileting unless physical assistance is provided by others 4-6 days per week.
N. Applicant in never capable of toileting without physical assistance 7 days per week.

IF INCONTINENT: Does applicant require physical assistance from another person to perform incontinent care on an ongoing basis? Check Type(s): [ ] Bowel [ ] Bladder

A. Applicant is always capable of performing incontinence care without physical assistance.
U. Applicant is incapable of performing incontinence care and requires physical assistance 1-3 days per week.
UN. Applicant is incapable of performing incontinence care and requires physical assistance 4-6 days per week.
N. Applicant is never capable of performing incontinence care and requires physical assistance 7days per week

If catheter/ ostomy present: Does applicant require physical assistance from another person to perform catheter/ ostomy care on an ongoing basis?

A. Applicant is always capable of performing catheter/ ostomy care without physical assistance.
U. Applicant is incapable of performing catheter/ ostomy care and requires physical assistance 1-3 days per week.
UN. Applicant is incapable of performing catheter/ ostomy care and requires physical assistance 4-6 days per week.
N. Applicant is never capable of performing catheter/ ostomy care and requires physical assistance 7days per week.

V. ORIENTATION:

The applicant is disoriented to person (e.g., fails to remember own name, or recognize immediate family members), place (e.g., does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make decisions that prevent risk of harm)

*Approval of this deficit requires documentation of the specific orientation deficit(s), including the frequency of occurrence of such deficit(s), and the impact of such deficit(s) on the applicant.

Is applicant orientedtoPERSON (fails to remember own name, or recognizesfamily),PLACE (does not know residence is a NF), or event/situation (e.g., is unaware of current circumstances in order to make decisions that prevent risk of harm)?

A. Applicant is always oriented to person, place and event/situation.
U. Applicant is not oriented to person or place or event/situation 1-3 days per week.
UN. Applicant is not oriented to person or place or event/situation 4-6 days per week.
N. Applicant is never oriented to person or place or event/ situation 7 days per week.

VI. COMMUNICATION:

Expressive Communication

The applicant is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) in a manner that can be understood by others, including through the use of assistive devices

*Approval of this deficit requires documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of communication assistance required.

EXPRESSIVE: Can applicant reliably communicate basic wants and needs?

A. Applicant is always capable of reliably communicating basic needs and wants.
U. Applicant is incapable of reliably communicating basic needs and wants and requires continual intervention 1-3 days per week.
UN. Applicant is incapable of reliably communicating basic needs and wants, and requires continual intervention 4-6 days per week.
N. Applicant is never capable of reliably communicating basic needs and wants, and requires continual intervention 7 days per week.

Receptive Communication
The applicant is incapable of understanding and following very simple instructions and commands without continual intervention.

*Approval of this deficit requires documentation of the medical condition(s) contributing to this deficit, as well as the specific type and frequency of communication assistance required.

RECEPTIVE: Can applicant understand and follow very simple instructions without continual intervention?

A. Applicant is always capable of understanding and following very simple instructions and commands without continual intervention.

U. Applicant is incapable of understanding and following very simple instructions and commands without continual intervention 1-3 days per week.

UN. Applicant is incapable of understanding and following very simple instructions and commands without continual intervention 4-6 days per week.

N. Applicant is never capable of understanding and following very simple instructions and commands without continual intervention 7days per week.

VII. MEDICATION:

The applicant is not cognitively or physically capable of self-administering prescribed medications at the prescribed schedule despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to applicant, reassurance of the correct dose, and the use of assistive devices including a prepared medication box. An occasional lapse in adherence to a medication schedule shall not be sufficient for approval of this deficit; the applicant must have physical or cognitive impairments which persistently inhibit his or her ability to self-administer medications.

*Approval of this deficit requires evidence that such interventions have been tried or would not be successful, and that in the absence of intervention, the applicant's health would be at serious and imminent risk of harm.

Is applicant physically or cognitively able to self-administer medications with limited assistance from others (as described above)? This excludes sliding scale insulin which is documented in the skilled services section.

A. Applicant is always capable of self-administration of prescribed medications.

U. Applicant is incapable of self-administration of prescribed medications without physical intervention 1-3 days per week.

UN. Applicant is incapable of self-administration of prescribed medications without physical intervention 4-6 days per week.

N. Applicant is never capable of self-administration of prescribed medications without physical intervention 7 days per week.

NOTE: If 'UN' or 'N' is marked, please list medications for which assistance is needed, and provide an explanation regarding why the applicant is unable to self-administer with limited help from others:

_____

_____

VIII. BEHAVIOR:

The applicant requires persistent staff or caregiver intervention and supervision due to an established and persistent pattern of behavioral problems which are not primarily related to a mental health condition (for which mental health treatment would be the most appropriate course of treatment) or a substance abuse disorder (for which substance abuse treatment would be the most appropriate course of treatment), and which, absent such continual intervention and supervision, place the applicant or others at imminent and serious risk of harm. Such behaviors may include physical aggression (including assaultive or self-injurious behavior, destruction of property, resistive or combative to personal and other care, intimidating/threatening, or sexual acting out or exploitation) or inappropriate or unsafe behavior (including disrobing in public, eating non-edible substances, fire setting, unsafe cooking or smoking, wandering, elopement, or getting lost).

*Approval of this deficit requires documentation of the specific behaviors and the frequency of such behaviors.

Does applicant require persistent intervention for an established and persistent pattern of behavioral problems not primarily related to a mental health or substance abuse disorder?

A. Applicant always requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 7 days per week.

U. Applicant requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 4-6 days per week.

UN. Applicant requires persistent staff or caregiver intervention due to an established and persistent pattern of behavioral problems 1-3 days per week.

N. Applicant never requires persistent intervention due to an established and persistent pattern of behavioral problems.

NOTE: If 'A' or 'U' is marked, please specify the behavioral problems requiring continual staff or caregiver intervention:

_____

_____

Skilled Nursing or Rehabilitative Services

The applicant requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through daily home health visits.

Approval of such skilled nursing or rehabilitative services requires a physician's order and other documentation as specified in the PAE. Level 2 reimbursement for rehabilitative services and acuity points for such rehabilitative services shall not be approved for chronic conditions, exacerbations of chronic conditions, weakness after hospitalization, or maintenance of functional status, although the NF shall be required to ensure that appropriate services and supports are provided based on the individualized needs of each resident.

SKILLED NURSING & REHABILITATIVE SERVICES (Check all that apply and indicate frequency needed):

Reimbursement for Level 2 Nursing Facility Services requires specific supporting documentation for approval. The required supporting documentation is specified below *in italics* for *each* skilled or rehabilitative service. The specified documentation must be submitted with the PAE. *TennCare does not provide reimbursement for rehabilitative services (see below) for chronic conditions, exacerbations of chronic conditions, or weakness after hospitalization. Rehabilitative services for maintenance of functional status (e.g., routine range of motion exercises, stand-by assistance during ambulation, or applications of splints/braces) are not considered skilled level services.

NEED	SERVICE	DURATION	
		Requested Start Date	Requested End Date
☐	Wound Care for Stage 3 or 4 decubitus *Physician's order and Wound Assessment (describing characteristics and measurements)*	___/___/___	___/___/___
☐	Other Wound Care (i.e., infected or dehisced wounds) *Physician's order and Wound Assessment (describing characteristics and measurements)*	___/___/___	___/___/__
☐	Injections, sliding scale insulin *Physician's order for Sliding Scale protocol and Blood Glucose Monitoring Log*	___/___/___	___/___/__
☐	Injections, other: IV, IM *Physician's Orders – Specify Frequency and Duration*	___/___/___	___/___/__
☐	Intravenous fluid administration *Physician's Orders – Specify Frequency and Duration*	___/___/___	___/___/__
☐	Isolation precautions *Lab report with organism and diagnosis to support isolation*	___/___/___	___/___/__
☐	*Occupational Therapy by OT or OT assistant *Physician's Orders and OT Evaluation – Specify Frequency, Duration, and Diagnosis*	___/___/___	___/___/__
☐	*Physical Therapy by PT or PT assistant *Physician's Orders and PT Evaluation – Specify Frequency, Duration, and Diagnosis*	___/___/___	___/___/__
☐	Teaching Catheter/Ostomy care *Skilling for new catheter/Ostomy only – Specify teaching plan*	___/___/___	___/___/__
☐	Teaching self-injection *Skilling for new diabetics only – Specify teaching plan*	___/___/___	___/___/__
☐	Total Parenteral nutrition *Physician's Orders*	___/___/___	___/___/__
☐	Tube feeding, enteral *Physician's Orders*	___/___/___	___/___/__
☐	Peritoneal Dialysis *Physician's Orders*	___/___/___	___/___/__
☐	PCA Pump *Physician's Orders*	___/___/___	___/___/__
☐	New tracheostomy or old tracheostomy requiring suctioning through the tracheostomy multiple times per day at less frequent intervals, i.e., < every 4 hours *Physician's Orders, including date of tracheostomy and documentation of frequency of suctioning required, if applicable*	___/___/___	___/___/__
☐	Other *If other requests, submit supporting documentation.*	___/___/___	___/___/__

ENHANCED RESPIRATORY CARE RATES

Reimbursement for Level 2 Nursing Facility Services at one of the Enhanced Respiratory Care rates (and an HCBS Cost Neutrality Cap based on eligibility for such enhanced level of reimbursement) is limited to persons who meet specified medical eligibility criteria below. Approval of CV or TS reimbursement (or a Cost Neutrality Cap based on eligibility for such enhanced level of reimbursement) requires specific supporting documentation. The required supporting documentation is specified below for each rate. Documentation requirements may be modified for purposes of a Cost Neutrality Cap Determination, *as noted in italics below*. The specified documentation must be submitted with the PAE and/or Cost Neutrality Determination, as applicable.

☐	**Chronic Ventilator Services – Provide all of the following:** • Documentation which demonstrates that the person is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula) • A physician's order for ventilator care *(For Cost Neutrality, submit the physician's order for nursing services.)* • A detailed treatment plan developed with input and participation from a pulmonologist or physician with experience in ventilator care signed by the treating physician or a licensed respiratory care practitioner who will oversee the ventilator care *(For Cost Neutrality, submit the care plan for home-based nursing services.)* **NOTE:** Reimbursement for NF services at the CV rate can be made *only* to NFs that meet standards of care for delivery of ventilator services, as set forth in TennCare Rules.
☐	**Frequent Tracheal Suctioning – Provide all of the following:** • Documentation which demonstrates that the person has a functioning tracheostomy requiring suctioning **through the tracheostomy** at a minimum, multiple times per 8-hour shift. The suctioning must be required to remove excess secretions and/or aspirate **from the trachea**, which cannot be removed by the patient's spontaneous effort. (Suctioning of the nasal or oral cavity does **not** qualify for this higher level of reimbursement.) • A physician's order for tracheal suctioning *(For Cost Neutrality, submit the physician's order for nursing services to perform tracheal suctioning.)* • A detailed treatment plan signed by the treating physician, licensed registered nurse, or licensed respiratory professional who will oversee the intensive respiratory care *(For Cost Neutrality, submit the care plan for home-based nursing services to perform tracheal suctioning.)* • *If some of the care is performed by family members or other caregivers, submit detailed documentation of the care provided by family members or other caregivers, in addition to physician's orders and a nursing care plan for services performed by a registered or licensed nurse.* **NOTE:** The NF must ensure the availability of necessary equipment, supplies, and appropriately trained and licensed nurses or licensed respiratory care practitioners to perform the specified tasks.

PAE CERTIFICATION FORM

APPLICANT'S NAME _____
SSN: _____ **PAE REQUEST DATE:** _____

REQUIRED ATTACHMENTS (When a PAE is required, the following attachments **must** be included)

- ✓ A recent History and Physical (completed within 365 days of the PAE Request Date or date of Physician Certification below, whichever is earlier) OR other recent medical records supporting the applicant's functional and/or skilled nursing or rehabilitative needs;
- ✓ Current Physician's Orders for NF service and/or level of NF reimbursement requested (as applicable); and
- ✓ Supporting documentation for reimbursement of skilled nursing and/or rehabilitative services or for a higher Cost Neutrality Cap (as applicable) based on the need for such services.

CERTIFICATION OF ASSESSMENT *May be completed by a Physician, Nurse Practitioner, Physician Assistant, Registered or Licensed Nurse, or Licensed Social Worker.*

I certify that the level of care information provided in this PAE is accurate. I understand that this information will be used to determine the applicant's eligibility and/or reimbursement for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.

Assessor Name: _____ Credentials: _____ Date: _____

PHYSICIAN CERTIFICATION of LEVEL OF CARE (NF Services Only)

Must be completed by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist.

I certify that the applicant requires the level of care provided in a nursing facility and that the requested long-term care services are medically necessary for this applicant. Medically necessary care in a nursing facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis. I understand that this information will be used to determine the applicant's eligibility for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties**. Original signature, NPI, Medicaid ID, and date must be completed by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist with the date the level of care is certified.**

DIAGNOSES relevant to applicant's functional and/or skilled nursing needs:

_____
_____
_____

Printed Name of LOC Certifier: _____NPI: _____ Medicaid ID: _____

Signature and Credentials: _____ Signature Date: _____

COMPLETE THE SECTION BELOW ONLY IF THE PAE MUST BE RECERTIFIED

CERTIFICATION UPDATE: I certify that the applicant's medical condition on the recertified PAE is consistent with that described in the initial certification and that Nursing Facility services (or an equivalent level of HCBS) are medically necessary for the applicant.		
Recert PAE Request Date	**Signature of Physician (for NF)**	**Date of Signature**