




Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Long-Term-Care Facility Bulletin 115
December 2020

TO: All Nursing Facilities and Chronic Disease and Rehabilitation Inpatient Hospitals Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth 

RE: **Revised Status Change for Members in a Nursing Facility or Chronic Disease and Rehabilitation Inpatient Hospital (SC-1) Form - Updated**

Background

The Status Change for Members in a Nursing Facility or Chronic Disease and Rehabilitation Inpatient Hospital (SC-1) form has been updated as of January 1, 2021 to reflect the expansion of Family Assistance to provide 100 days in a nursing facility or CDRH. Items 32 and 33 have been added to the SC-1 form to include questions related to Family Assistance eligibility.

Updates to Section 3

Item 32: Does member currently have the MassHealth Family Assistance 100-day coverage?

This item allows the nursing facility staff to inform MassHealth Enrollment Center (MEC) staff whether the institutionalized individual has MassHealth Family Assistance 100-day coverage for the current admission.

Item 33: MassHealth Family Assistance 100-day coverage end date for this admission

This item allows the nursing facility staff to inform MassHealth Enrollment Center (MEC) staff of the end date for the MassHealth Family Assistance 100-day coverage for the institutionalized individual.

Required Action

The nursing facility must ensure that all required fields on the SC-1 form, as described on the instructions page of the form, are completed before submission.

Please Note: If the MEC receives an incomplete SC-1 form, the form will be returned to the nursing facility for completion. The MEC will process the case further only when it receives the completed SC-1 form.

Using the New SC-1 Form

You can begin using the SC-1 form on January 1, 2021. However, if you submit an old SC-1 form after January 31, 2021, please make sure you include the service location along with your provider ID.

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The SC-1 form can be downloaded from the MassHealth website at <https://www.mass.gov/lists/masshealth-provider-forms-by-provider-type-h-m#long-term-care>. Request for paper copies of this form must be submitted in writing and faxed to (617) 988-8973 or mailed to the following address.

MassHealth LTSS
P.O. Box 159108
Boston, MA 02112

A sample of the revised SC-1 form is attached.

Frequently asked questions about the MassHealth Family Assistance benefit in nursing facilities and CDRHs can be found online at www.mass.gov/media/2234731/download

MassHealth Website

This bulletin is available on the [MassHealth Provider Bulletins](#) web page.

To sign up to receive email alerts when MassHealth issues new bulletins and transmittal letters, send a blank email to join-masshealth-provider-pubs@listserv.state.ma.us. No text in the body or subject line is needed.

Questions

If you have any questions about the information in this bulletin, please contact the MassHealth Customer Service Center at (800) 841-2900, email your inquiry to providersupport@mahealth.net, or fax your inquiry to (617) 988-8974.



Status Change for a Member in a Nursing Facility or Chronic Disease and Rehabilitation Inpatient Hospital

(Admission or Discharge of MassHealth Members)

SECTION 1 (Items 1 through 12 must be completed.) PLEASE PRINT OR TYPE

1. Provider ID/Service Location		2. Provider Name		3. Provider Telephone Number	
4. Provider Address			5. Reason for Submission <input type="checkbox"/> New SC-1 <input type="checkbox"/> Change to Existing SC-1		
6. Member Last Name		7. Member First Name		8. Middle Initial	
9. Member Home Address					
10. Member Date of Birth		11. Member Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		12. Member ID or SSN (Provide SSN only if member ID is not available.)	

SECTION 2 (Please read instructions on the back of this form to complete this section.)

13. Type of Status Change <input type="checkbox"/> Admit <input type="checkbox"/> Discharge <input type="checkbox"/> Both admit and discharge		15. Admitted From <input type="checkbox"/> Home/community <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing facility <input type="checkbox"/> Rest home		16. Admission Date	
14. Type of Bed Nursing <input type="checkbox"/> Facility <input type="checkbox"/> Chronic/Rehab				17. Discharge Date	
18. Discharge Reason <input type="checkbox"/> Discharged to Home/community <input type="checkbox"/> Discharged to a rest home <input type="checkbox"/> Discharged to a hospital <input type="checkbox"/> Left against medical advice <input type="checkbox"/> Discharged to a long-term-care facility <input type="checkbox"/> Deceased. Date of death:				<input type="checkbox"/> Other (explain):	

SECTION 3 (Please read instructions on the back of this form to complete this section.)

19. MassHealth Requested Payment Date		20. Reason for MassHealth Requested Payment Date			
21. Length of Stay for Nursing Facility Services <input type="checkbox"/> Short-term (six months or less) <input type="checkbox"/> More than six months <input type="checkbox"/> Short-term-care stay terminated		22. Clinical Eligibility for Nursing Facility Services <input type="checkbox"/> Approved <input type="checkbox"/> Approved – short term Effective date of decision: <input type="checkbox"/> Denied			

Complete Items 23, 24, 25 if member is expected to stay six months or less.

23. Certification of Short Term Stay. I certify that the above-named member's expected length of stay is		24. Physician's Signature		25. Date	
26. Public Rate Amount \$		27. Private Rate Amount \$		28. Medicare Upon Admission? <input type="checkbox"/> Yes <input type="checkbox"/> No	
29. Medicare End Date				31. MCO End Date (N/A for SCO/PACE)	
30. Does member have managed care organization (MCO), Program for All-Inclusive Care for the Elderly (PACE), or Senior Care Options (SCO) coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			32. Does member currently have the MassHealth Family Assistance 100-day coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
33. MassHealth Family Assistance 100-day coverage end date for this admission			35. For new admission, is Level 1 OBRA/PASARR form attached? <input type="checkbox"/> Yes <input type="checkbox"/> No		
34. Is the nursing facility clinical eligibility determination form attached? <input type="checkbox"/> Yes <input type="checkbox"/> No				36. Date	
35. Signature of authorized representative completing the SC-1 form.				36. Date	

INSTRUCTIONS FOR COMPLETING THE SC-1 FORM

Please see instructions below for the fields that are not self-explanatory. For all items with check boxes, please make sure you check one box. As noted below, some fields are required to be completed.

SECTION 1

Items 1 through 12 are required to be completed on all SC-1 forms.

Item 1	Provider ID/Service Location	Enter the nine-digit provider ID followed by the one-character location code.
Item 12	Member ID or SSN	Enter the 12-digit MassHealth member ID number. Enter the social security number (SSN) only if member ID is not available.

SECTION 2

Item 13 is required to be completed.

- If Item 13 is "Admit," items 14-16 are required to be completed.
- If Item 13 is "Discharge," items 17-18 are required to be completed.
- If Item 13 is "Both admit and discharge," items 14-18 are required to be completed.

Item 18	Discharge Reason	Select the reason for discharge. If none of the reasons explains the situation clearly, use the other field to explain.
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SECTION 3

- If Item 13 is "Admit" or "Both admit and discharge," items 19-22 and 26-33 are required to be completed.
- If Item 21 is "Short-term (six months or less)," items 23-25 are required to be completed.
- Items 34-35 are required to be completed on all SC-1 forms.

Item 19	MassHealth Requested Payment Date	Enter the start date for which MassHealth payment is requested.
Item 20	Reason for MassHealth Requested Payment Date	Describe the reason for the request date in Item 19 (e.g., Medicare days ended, private pay ended).
Item 21	Length of Stay for Nursing Facility Services	The nursing facility should enter the information as it appears on the clinical eligibility determination completed by MassHealth or its agent.
Item 22	Clinical Eligibility for Nursing Facility Services	The nursing facility should enter the information as it appears on the clinical eligibility determination completed by MassHealth or its agent. If clinical eligibility for MassHealth payment of nursing facility services has been denied, do not submit this form as the facility will not be paid.
Item 26	Public Rate Amount	Enter the public facility rate for this member.
Item 27	Private Rate Amount	Enter the private facility rate for this member.
Item 32	Family Assistance 100-day Coverage	Check the "Yes" box if member has MassHealth Family Assistance, and is eligible for 100-day coverage for this admission.
Item 33	MassHealth Family Assistance 100-Day Coverage End Date for this Admission	Enter end date for MassHealth Family Assistance 100-day coverage for this admission.
Item 34	Is the nursing facility clinical eligibility determination form attached?	Check the "Yes" box if the nursing facility screening notification form is attached. Otherwise, check "No." If the form is not attached, the member will not be coded for long-term-care services.
Item 35	OBRA/PASARR form attached?	For new admissions only, check the "Yes" box if Level 1 OBRA/PASARR form is attached to the SC-1 form. Otherwise, select "No."