Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Long Term Care Facility Bulletin 99
May 2009

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

From: Tom Dehner, Medicaid Director TD

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

Background

The Status Change for Members in a Nursing Facility or Chronic Disease and Rehabilitation Inpatient Hospital (SC-1) Form has been redesigned for NewMMIS implementation. The new form will allow MassHealth to collect additional statistical data about its members.

The form now has three distinct sections. Instructions to fill in the form are provided on page two of the form. Some of the major changes for each section of the SC-1 form are described below.

Please Note: This form will no longer be used for rest home residents. A new form, the Status Change for Residents in a Rest Home (SC-1-RH) Form, has been designed for rest home members only.

Section 1

Item 1: Provider ID/Service Location

With the implementation of NewMMIS, all MassHealth providers will have a provider identifier and service location code. This will be a nine-digit number followed by a one-character service location code. Enter this number in Item 1 of the SC-1 form.

Item 12: Member ID or SSN

With the implementation of NewMMIS, all MassHealth members will be given a unique member identification number that is *not* their social security number (SSN). The new MassHealth cards will display the member ID number instead of the SSN.

If this number is available, enter it in Item 12 of the SC-1 form. If the individual listed on the SC-1 form is a MassHealth applicant but has not received a member ID number yet, enter their SSN. To access member ID information, go to the NewMMIS eligibility verification system (EVS), the former REVS.

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Section 2

Item 15: Admitted From

Enter the living situation the individual was residing in prior to admission. It could be home/community, hospital, nursing facility, or rest home.

Item 18: Discharge Reason

This item includes the types of living arrangements mentioned under Item 15, and lists reasons for discharge. If none of the reasons applies, use the "Other" field to explain.

Section 3

Item 20: Reason for MassHealth Requested Payment Date

This item allows the nursing facility staff to inform the MassHealth Enrollment Center (MEC) staff why they are requesting a specific MassHealth start date (e.g., the individual paid privately through a certain date).

Item 21: Length of Stay for Nursing Facility Services

If the short-term box is checked on the SC-1 form, a physician's signature is needed, and the Clinical Eligibility Determination Form should also show a short-term approval. If the physician indicates short-term, but the Clinical Eligibility Determination Form indicates more than six months (formerly long-term approval), the clinical approval overrides the physician's statement of short-term stay.

Item 22: Clinical Eligibility for Nursing Facility Services

This item lists the type of approval or denial, and an effective date of the decision. If clinical eligibility is denied, the facility will not be paid. The effective date of the decision is the date located in the lower-left corner of the Clinical Eligibility Determination Form.

Item 30: Managed Care Organization (MCO) Coverage

The nursing facility must inform the MEC staff if the institutionalized individual was a member of a managed care organization (MCO), Program for All-inclusive Care for the Elderly (PACE), or Senior Care Options (SCO), and when the coverage ended. However, this end date is not applicable to SCO and PACE.

Please Note: MCO plans include a nursing home component, and a certain number of days may be paid for by an MCO for a member in a nursing facility.

(continued on next page)

Section 3
(cont.)

Item 33: For new admission, is Level 1 OBRA/PASARR form attached?

All members admitted to a nursing home from a hospital should have a Level I OBRA/PASARR form completed, and this form should be included with the SC-1 form for every new admission. Check Yes if the form is included, and No if it is not included.

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 starting May 26, 2009. However, if you submit an old SC-1 form after May 26, 2009, please make sure you include the service location along with your provider ID.

The SC-1 form can be downloaded from the MassHealth Web site at www.mass.gov/masshealth. 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
ATTN: Forms distribution
P.O. Box 9118
Hingham, MA 02043

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

Questions

If you have questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

Reset Form

MassHealth
Commonwealth of Massachusetts · EOHHS
www.mass.gov/masshealth

Status Change for Members 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.)

1. Provider ID/Service Location	2. Provider Name	3. Provider Telephone Number
4. Provider Address		5. Reason for Submission ☐ New SC-1 ☐ 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 ☐ Female ☐ 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 for how to complete this section.)

13. Type of Status Change
- ☐ Admit
- ☐ Discharge
- ☐ Both admit and discharge

14. Type of Bed
- ☐ Nursing facility
- ☐ Chronic/Rehab

15. Admitted From
- ☐ Home/community
- ☐ Hospital
- ☐ Nursing facility
- ☐ Rest home

16. Admission Date
/ /

17. Discharge Date
/ /

18. Discharge Reason
- ☐ Discharged to Home/community
- ☐ Discharged to a hospital
- ☐ Discharged to a long-term-care facility
- ☐ Discharged to a rest home
- ☐ Left against medical advice
- ☐ Deceased. Date of death: ___/___/___
- ☐ Other (explain): _____

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

19. MassHealth Requested Payment Date / /	20. Reason for MassHealth Requested Payment Date

21. Length of Stay for Nursing Facility Services
- ☐ Short-term (six months or less)
- ☐ More than six months
- ☐ Short-term-care stay terminated

22. Clinical Eligibility for Nursing Facility Services
- ☐ Approved
- ☐ Approved – short term
- ☐ Denied

Effective date of decision: ___/___/___

Complete Items 23, 24, 25 only if member's expected stay is 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? ☐ Yes ☐ No	29. Medicare End Date / /
30. Does member have managed care organization (MCO), Program for All-Inclusive Care for the Elderly (PACE), or Senior Care Options (SCO) coverage? ☐ Yes ☐ No			31. MCO End Date (N/A for SCO/PACE) / /
32. Is the nursing facility clinical eligibility determination form attached? ☐ Yes ☐ No		33. For new admission, is Level 1 OBRA/PASARR form attached? ☐ Yes ☐ No	
34. Signature of authorized representative completing the SC-1 form.		35. Date / /	

SC-1 (Rev. 05/09)

SEE REVERSE SIDE FOR INSTRUCTIONS.

INSTRUCTIONS FOR COMPLETING THE SC-1 FORM (PLEASE PRINT OR TYPE.)

Below are instructions for specific fields. All other fields are 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.

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	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 33	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."