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

Member's Name: _____

Member's MassHealth No.: _____

Date of Determination: _____

MassHealth Payment of Nursing-Facility Services

This notice is sent in response to your request for MassHealth authorization for nursing-facility services. In order to qualify for nursing-facility services, you must be both clinically and financially eligible for these services. *This notice is about your clinical eligibility.* You will receive a separate notice about your financial eligibility**.**

1. MassHealth Assessments

Assessments to determine clinical eligibility for nursing-facility services are conducted by _____Hospital on behalf of MassHealth. A hospital nurse reviewed your case in accordance with MassHealth regulations at 130 CMR 456.408, and has determined the following. To view MassHealth regulations, go to www.mass.gov/masshealth.

☐ You **are** clinically eligible for nursing-facility services for a **short-term** stay up to 30 days because nursing facility services are medically necessary as required by MassHealth regulations at 130 CMR 456.409. Your continued clinical eligibility is subject to review. See 130 CMR 456.408.

☐ You **are** clinically eligible for nursing-facility services because nursing facility services are medically necessary as required by MassHealth regulations at 130 CMR 456.409. Your continued clinical eligibility is subject to review. See 130 CMR 456.408.

☐ You **are not** clinically eligible for nursing-facility services because of the following reason.

- ☐ Nursing-facility services are not medically necessary, as required by MassHealth regulations at 130 CMR 456.409.
- ☐ Nursing-facility services are not medically necessary because your medical needs can be met in the community, and services are available. See 130 CMR 456.408(A)(2).

☐ You **are not** eligible for nursing-facility services because the Department of Developmental Services/Department of Mental Health, in its capacity as the designated Preadmission Screening Resident Review (PASRR) authority, has determined that nursing-facility admission is not appropriate for you. (*Please see page 2 of this notice, as well as the attached PASRR Determination Notice*).

continued →

Member Name: _____

2. Preadmission Screening Resident Review (PASRR) for Mental Illness, Mental Retardation, or Developmental Disability

Federal and state laws require that persons suspected of having mental illness, mental retardation, or developmental disability be evaluated in order to determine whether their admission to a nursing facility is appropriate. Such evaluations are conducted by the Department of Development Disability (DDS) or an agent of the Department of Mental Health (DMH), as appropriate. (See regulations at 42 CFR 483.108, 483.112(a), and 483.114).

In accordance with these regulations, the AIH nurse reviewed your medical needs and the following was determined.

☐ There is **no indication** of mental illness, mental retardation, or developmental disability.

☐ There is **an indication** of mental illness, mental retardation, or developmental disability, but one of the conditions described in 130 CMR 456.410 (C) applies, and therefore your case was not referred to DDS/DMH for evaluation.

❑ There is **an indication** of mental illness, mental retardation, or developmental disability and your case was referred to DDS/DMH, as appropriate, for further PASRR evaluation. In accordance with federal PASRR regulations, DDS/DMH has issued a PASRR Determination Notice with the following determination.

- ❑ Nursing-facility admission is appropriate for you. (*Please see attached PASRR Determination Notice*).
- ☐ Nursing-facility admission is not appropriate for you. (*Please see attached PASRR Determination Notice*).

Date of current PASRR Determination Notice: _____

_____ , RN
Acute Inpatient Hospital on behalf of MassHealth

3. Appeal Rights

You have the right to appeal this decision, and, if applicable, the attached DDS/DMH PASRR Determination Notice. (Please see attached information about your right to appeal through the fair-hearing process.)

OFFICIAL USE ONLY

_____, RN
ASAP on behalf of MassHealth

Date(s): _____

_____, RN
Print name.

_____
ASAP address

Print Form

Clear Form