

# 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 \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_- email address \_\_\_\_\_

## SERVICE REQUESTED:

HCBS Group 2 or 3 Check Target Group below, as applicable:  
 Age 65 +  Physically disabled (21 +) – specify diagnosis or condition \_\_\_\_\_

Is ERC being requested?

Yes  No

Request Safety Determination?

Yes  No

Submission Request Type:

New CHOICES Applicant  Change in current LOC  Current CHOICES member, current PAE ending  
 CN Cap determination

HCBS Employment and Community First  
 Group 4  Group 5  Group 6

Target Group, check all that apply:

ID  DD  Living at home with family

Specify diagnosis or condition \_\_\_\_\_

Request Safety Determination?

Yes  No

Submission Request Type:

New ECF Applicant  Change in current LOC  Current ECF member, current PAE ending  
 CN/Expenditure Cap exception or change

Nursing Facility

Is ERC being requested?

Yes  No

Request Safety Determination?

Yes  No

Submission Request Type:

New CHOICES Applicant  Change in current LOC  Current CHOICES member, current PAE ending  
 Hospice \*HospiceservicesarenotLTCservices.DonotsubmitPAE!

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 required 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 without physical help from others?**

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

#### IV. TOILETING

The applicant requires physical assistance from another person to use the toilet on an ongoing basis

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

\*Approval of this deficit requires documentation of the specific type and frequency of toileting assistance required.

- 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 is never capable of toileting without physical assistance 7 days per week.

**IF INCONTINENT: Applicant requires physical assistance from another person to perform incontinent care on an ongoing basis.** Check Type(s): [ ] Bowel [ ] Bladder

\* The applicant requires physical assistance from another person to perform incontinence care.

- 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 7 days per week

**If catheter/ ostomy present: Applicant requires physical assistance from another person to perform catheter/ ostomy care on an ongoing basis.**

\*The applicant requires physical assistance from another person to perform ostomy care, or catheter care.

- 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 7 days 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 disoriented to PERSON (remembers name; recognizes family), 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 disoriented to person or place or event/situation 1-3 days per week.
- UN. Applicant is disoriented 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)?**

- 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:

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**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 behavior 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:

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**Skilled Nursing or Rehabilitative Services**

Indicate if the applicant requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a 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. 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.

APPLICANT'S NAME \_\_\_\_\_

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

Reimbursement 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 SMTS 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

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

**ENHANCED RESPIRATORY CARE RATES**

Reimbursement for 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.

<input type="checkbox"/>	<p><b>Chronic Ventilator Services</b></p> <p><b>Approval Criteria:</b></p> <ul style="list-style-type: none"> <li>• Applicant must be ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula).</li> <li>• On a case-by-case basis, TennCare may, subject to additional medical review by the MCO or Eventa, authorize Chronic Ventilator Reimbursement for an applicant who is ventilator dependent with a progressive neuromuscular disorder, spinal cord injury, or chronic respiratory failure and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least 12 hours each day in order to avoid or delay tracheostomy.</li> <li>• Treatment plan must be developed with input and participation from a pulmonologist or physician with experience in ventilator care and signed by the treating physician or a licensed respiratory professional who will oversee the intensive respiratory care.</li> </ul> <p><b>Documentation Requirements:</b></p> <ul style="list-style-type: none"> <li>• Physician order – for ventilator at least 12 hours per day</li> <li>• Detailed treatment plan signed by the treating physician, licensed RN or licensed respiratory professional who will oversee the intensive respiratory care;</li> <li>• A care plan for services to be performed by a registered or licensed nurse and/ or respiratory therapist; or Plan for care to be rendered by family members, with documentation of their ability to perform such care</li> </ul> <p><b>Approval Period</b></p> <ul style="list-style-type: none"> <li>• Up to 6 months</li> </ul> <p>Note: After initial 6 month approval, with a new request, may be approved for more than 6 months if person is in persistent vegetative state, or has a progressive neurological disorder such as ALS.</p>
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### **Secretion Management Tracheal Suctioning**

#### **Approval Criteria:**

- Patient must have a functioning tracheostomy and a copious volume of secretions, and require:
  - invasive tracheal suctioning, at a minimum, once every 3 hours with documented assessment pre- and post-suctioning; or
  - the use of mechanical airway clearance devices and/or heated high flow molecular humidification via the tracheostomy, at a minimum, 3 times per day with documented assessment pre-and post
- The suctioning (or airway clearance, as applicable) must be required to remove excess secretions and/or aspirate from the trachea, which cannot be removed by applicant's spontaneous effort.

#### **Documentation Requirements:**

- Physician order
- Detailed treatment plan signed by the treating physician, licensed RN or licensed respiratory professional who will oversee the intensive respiratory care;
- A care plan for services to be performed by a registered or licensed nurse and/ or respiratory therapist; or Plan for care to be rendered by family members, with documentation of their ability to perform such care.

#### **Approval Period**

- 30 Days

Note: TennCare may on a case by case basis approve Secretion Management for more than thirty (30) days e.g., if a person has ALS or another progressive neuromuscular disorder, spinal cord injury or chronic respiratory failure, or is in a persistent vegetative state, where ongoing secretion management tracheal suctioning is expected to continue.



# 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