



INSTRUCTIONS

FOR COMPLETING THE

MEDICAL ELIGIBILITY DETERMINATION FORM

(MED FORM)

BUREAU OF ELDER & ADULT SERVICES

July 1, 2001

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INTRODUCTION: PHILOSOPHY AND INTENT OF MED

The Medical Eligibility Determination (MED) form is set up in sections. The language, definitions, and format of the MED form are similar to that used in the MDS 2.0 (Minimum Data Set) system, which is used in the case mix demonstration project. This similarity makes data collection easier across long-term care programs and settings. (Definitions and time frames had to be modified in some areas of the MED form in order to utilize the form in a community setting).

The form was designed to be an objective tool that is easily coded. Each subsection of the manual includes the “how to complete” instructions and the time frames in which to measure the person’s abilities. The design facilitates immediate eligibility determination by the assessor for multiple federal and state funded programs.

ASSESSOR RESPONSIBILITIES

Your general responsibilities as an assessor include:

- reading all training materials
- attending training sessions
- completing the assessments in a thorough, efficient, and timely manner according to the requirements specified in various policies
- maintaining confidentiality

CONFIDENTIALITY REQUIREMENTS

It is crucial that all information gathered from any source is treated as confidential: **NO INFORMATION CAN BE DIVULGED BY AN ASSESSOR IN ANY WAY THAT WOULD SERVE TO IDENTIFY AN INDIVIDUAL PERSON.** Try to conduct interviews with people in private. Keep all completed forms with you.

MEDICAL ELIGIBILITY DETERMINATION INSTRUCTIONS

[Note: Different programs have different financial eligibility requirements. In order to determine what community options a person can appropriately access based on financial eligibility, the assessor will need to know income and assets of the person and, where applicable, the person's household income and assets. This will facilitate knowing when to refer consumers to the Bureau of Family Independence and other community resources.]

BACKGROUND INFORMATION

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This section contains the person's demographic information as well as pertinent information to assist the assessor in reviewing programs for which the person may be eligible. This section may follow the person to prevent repetitive questioning and verification of demographic information by every provider. People need to give release of information authorization for this section to be shared with other providers. **THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND MUST BE COMPLETED ON EACH PAGE.** Providers may choose to type in their provider number and agency name and reproduce their own supply of forms.

SECTION HEADER

Medical Eligibility Header includes the following items: **Assessment Start Date, Name/Title of person coordinating assessment, Agency/Organization, Provider and Assessor number. Each person completing assessments for an agency should be assigned a unique assessor number. If and when the person leaves the agency, the number should be retired and never assigned to another assessor.**

ASSESSMENT START DATE: This date establishes a common reference point to reflect the person's status and expected care needs. For the month and day of the assessment, enter two digits each, using zero (0) in the first box for a 1-digit month or day; use four digits for the year.

NAME/TITLE OF PERSON COORDINATING ASSESSMENT: This should be the name of the person responsible for the completion of the assessment form. To the right of the name, enter this person's title.

AGENCY/ORGANIZATION: Enter the name of the agency or organization that is performing this assessment. To the right of the name, enter the phone number of the agency and extension of the coordinator, if applicable.

PROVIDER - ASSESSOR #: If applicable, enter the nine-digit Medicaid provider number of this agency/organization. This is the number assigned by Medicaid programs to your agency/organization. You can obtain this number from the Provider Relations Unit, Bureau of Medical Services. Each agency will need to assign individual assessor numbers to the nurses or social work staff assigned to complete assessments. Spaces for three digits have been provided. **Each person completing assessments for an agency should be assigned a unique assessor number. If and when the person leaves the agency, the number should be retired and never assigned to another assessor.** Data from the MED is collected by provider number and the Department will review data by the assessor number also.

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

- A.1 Applicant Name:** Print applicant's legal name clearly, using capital letters for first name, middle initial and last name.
- A.2 Address:** Give applicant's residential address and phone number at time of assessment. If person is in the hospital, give applicant's address prior to admission. If person is currently at a residential care facility or nursing home, give the name and address of that facility.
- A.3-A.5 ENTER THE FOLLOWING NUMBERS, STARTING IN THE LEFTMOST BOX.**
Enter one digit in each box. If there is no number, leave the boxes blank. Check the numbers to make sure you entered the digits correctly.
- A.3 Social Security No.:** Enter the applicant's Social Security number. This is a nine-digit number.
- A.4 Medicaid No.:** Enter the applicant's Medicaid number, if applicable. This is a nine-digit number issued by the State.
- A.5 Medicare No.:** Enter the applicant's Medicare number, if applicable. Be sure to include any letters that follow the Medicare number.

A.6A ASSESSMENT TRIGGER: Select the option that matches this referral request.

- 1. Service Need:** Referent requests an assessment based on the consumer's need for service. May be used for any referral requesting a specific assessment for the programs listed in Section 6B of the MED form. **Referrals for consumers currently active on programs managed by the HCCA (Private Duty Nursing (PDN) for adults, Adults with Disabilities Waiver, Elderly Waiver, Home Based Care) must be requested by the HCCA, with the exception of NF assessment requests for these consumers from hospitals, NFs, or BFI.** For an initial medication or venipuncture services assessment under Section 96, use "service need".
- 2. Reassessment due:** Only applies to people with currently complete and valid assessments due to expire, and reassessment is required to determine continued medical eligibility. For a reassessment for medication or venipuncture services, use Reassessment due.
- 3. Significant Medical Change:** Only applies to people with a currently complete assessment. Indicators of significant change must be met. **A significant change in status** is defined as a major change in the person's status that: is not self-limiting; impacts on more than one area of the person's health status; and requires interdisciplinary review and/or revision of the care plan. A significant change assessment may be requested if a change is consistently noted in two or more areas of decline, or two or more areas of improvement and results in a change in eligibility outcome. For programs managed by the HCCA, please refer to them to request a significant change reassessment. The HCCA will refer to the Assessing Services Agency (ASA) for a reassessment. For NFs who are requesting a significant change assessment, the referral should include the person's last two MDS assessments with the referral request. One of the MDS assessments submitted must be a significant change MDS.
- 4. Financial Change:** Only applies to people with a currently complete assessment, for whom financial eligibility because of income, assets, or funding has changed.

A.6B Program Assessment Requested: The following are the possible choices for assessment types requested in Section A:

Enter appropriate number for program assessment being completed.

1. **Long Term Care Advisory:** Any person who requests an assessment for long-term care services. **In order to comply with the State statute a preadmission LTC Advisory assessment must be completed on every consumer admitted to a nursing facility prior to admission, except when transferred from a hospital to SNF level of care under Medicare or other third party payor.** The consumer receives information regarding whether or not, based on the MED form, nursing facility level of care is necessary. Within thirty days (30) of the assessment date the consumer may choose another option for care and have the assessment “UPDATED” to a Medicaid decision if the Assessing Services Agency (ASA) receives notification from BFI, that a Medicaid financial application for nursing facility level of care has been filed. This is considered an initial assessment. This assessment is for advice only – no appeal rights available based on “advice only”. **The consumer receives an advisory plan of care for community based services and may or may not make a choice.**

NOTE PROCESS CHANGE: Updates of Advisory assessments to NF Medicaid decisions will **NOT** occur until the consumer enters the NF and the Assessing Services Agency (ASA) receives either a transfer form, fax or telephone referral request from the NF. If prior to admission to the NF, the Assessing Services Agency (ASA) receives a BFI/ LTC message form, the Assessing Services Agency (ASA) will complete the form with Awaiting Placement at home or hospital, with eligibility as of the assessment date and return the completed LTC (122) form to BFI. This alerts BFI that NF medical eligibility has been determined and BFI will proceed with financial eligibility determination. At admission to the NF, the original assessment is **updated** from advisory giving a 90-day reassessment date from the date of the original assessment. The Assessing Services Agency (ASA) will send a LTC message form to BFI indicating the move from awaiting placement to NF admission, being sure to complete the change in address section to the NF address. The ASA will forward all “updated” assessments to the NF, and eligibility notices to the consumer.

Hospital to NF or home to NF admissions: Nursing facilities forward the transfer form to the Assessing Services Agency (ASA) upon a consumer’s admission. A RN in central office or the RN assessor will complete the conversion assessment and return the converted background and outcome page to the Department within five (5) days. Concurrently a new letter of eligibility that includes the eligibility start date and reassessment date will be issued to the consumer. A copy of the “converted” assessment version (be sure to include all sections) and all other relevant paperwork will be forwarded to the nursing facility. A choice letter signed on the day of the assessment, will also be sent to the facility. Payment to the facility **cannot** begin until the transfer form is received and the awaiting placement status is converted to admission status.

2. **Adult Day Care Program:** Any person who wants to access adult day care at a licensed day care program must have an assessment completed to determine functional eligibility for any programs receiving BEAS funding. Assessing Services Agency (ASA) or day care program may do assessments. If the assessment is completed by the Assessing Services Agency (ASA), the

assessment includes an Advisory plan of care and is forwarded to the appropriate day care provider if the consumer makes a choice for this program and signs a release of information.

- 3. BEAS Homemaker:** Consumers who want to access homemaker services under the BEAS homemaker program. Assessing Services Agency (ASA) or homemaker provider may complete assessment. If the assessment is completed by the Assessing Services Agency (ASA), the assessment includes an Advisory plan of care and is forwarded to the appropriate homemaker provider. The BEAS contracted homemaker providers may complete the MED form to determine medical eligibility or may receive a completed assessment form from the Assessing Services Agency (ASA). Reassessments are conducted by the provider according to policy. Appeals apply as outlined in BEAS policy Section 40.
- 4. Medicaid Day Health:** Current Community Medicaid recipient who wants access to adult day care reimbursed by Medicaid. Person must have Community Medicaid and attend a licensed/certified Adult Day Care Medicaid provider for reimbursement to occur from the Medicaid State plan program. Assessing Services Agency (ASA) or day health program may do assessments. Both the initial and reassessments may be completed by the Medicaid day health provider. The 60-day appeal applies to initial assessments and the 10 and 60-day appeal applies to reassessments on consumers currently receiving services under this program. If the assessment is completed by the Assessing Services Agency (ASA), the plan of care is Advisory only and a copy of the completed MED form must be forwarded to the provider chosen by the consumer.
- 5. Consumer Directed PCA Program:** For current Medicaid recipients who want to access the Consumer Directed PCA program. The consumer applying must have a valid Community Medicaid card and be deemed medically eligible and cognitively capable of hiring, directing, training, supervising and firing their PCA. The Authorized Agent who administers the consumer-directed programs completes the assessment and the authorized plan of care. If the assessment is completed by the Assessing Services Agency (ASA), the plan of care is Advisory only and the assessment is valid for 30 days. A copy of the completed MED form will be forwarded to the HCCA for consumer-directed programs. Services cannot begin until the consumer has successfully completed skills training and hired a personal care attendant. The assessment will then be converted and plan of care authorized, giving 90-day eligibility from date of original assessment. Initial and reassessments are conducted according to policy. The 60-day appeal applies to initial assessments and the 10 and 60-day appeal applies to reassessments.
- 6. Home Based Care Program:** Consumers 18 years and older who want to access the State funded home based care program, care plan coordination by HCCA. Initial and reassessments are conducted according to policy by the Assessing Services Agency (ASA). Providers who believe a significant change or service need assessment is needed **MUST** contact the HCCA to authorize and request a reassessment. 10-day appeal applies to both initial and reassessments for this State funded program.
- 7. Physically Disabled Waiver:** Consumer determined medically eligible for nursing facility care and chooses to receive the care in the community. Must be determined cognitively capable to direct personal care services. The Authorized Agent who administers the consumer-directed programs completes the assessment to determine eligibility and authorize a plan of care. If the assessment is completed by the Assessing Services Agency (ASA), the plan of care is Advisory only and the assessment is valid for 30 days. A copy of the completed MED form will be forwarded to the

HCCA for consumer-directed programs. When there is a waiting list, consumers must be reassessed if their name comes up on the waiting list after 30 days from assessment date. Services cannot begin until the consumer has successfully completed skills training and hired a personal care attendant. The assessment will then be converted and plan of care authorized, giving 90-day eligibility from date of original assessment. Initial and reassessments are conducted according to policy. The 60-day appeal applies to initial assessments and the 10 and 60-day appeal applies to reassessments.

- 8. Elderly Waiver:** Persons 60 years or older (60 to 64 if disabled) determined medically eligible for nursing facility care and choose to receive that level of care at home. The 60-day appeal applies to initial assessments and the 10 and 60-day appeal applies to reassessments on consumers currently receiving services under this program. Providers who believe a significant change or service need assessment is needed **MUST** contact HCCA to authorize and request a reassessment.
- 9. Adults with Disabilities Waiver:** Persons 18-59 years old determined medically eligible for nursing facility care and choose to receive that level of care at home. The 60-day appeal applies to initial assessments and the 10 and 60-day appeal applies to reassessments on consumers currently receiving services under this program. Providers who believe a significant change or service need assessment is needed **MUST** contact HCCA to authorize and request a reassessment.
- 10. Private Duty Nursing /At Risk Level:** Current Medicaid recipient who wants to access community services of a RN, CNA or PCA. For recipients age 0-20, the Medicaid licensed provider conducts the assessment. For recipients age 21 or older, the ASA conducts the assessment to determine eligibility and authorize the plan of care. Providers who believe a significant change or service need assessment is needed **MUST** contact HCCA to authorize and request a reassessment. The 60-day appeal applies to initial assessments and the 10 and 60-day appeal applies to reassessments on consumers currently receiving services under this program.
- 11. Adult Family Care Home:** Current Medicaid recipients who want to be admitted to an Adult Family Care Home. Adult Family Care Homes are residential style homes where residential care services are provided for six or fewer people. Adult Family Care Homes may complete the assessment. Persons must meet the functional criteria and be 18 years of age and older. Medical eligibility determines level of monthly reimbursement to the home, based on the assessment outcome. The 60-day appeal applies to initial assessments and the 10 and 60-day appeal applies to reassessments on consumers currently receiving services under this program.
- 12. Extended Level PDN:** Medicaid recipients who require hospital level of care and are determined medically eligible for that level of care and receive it in their home. For recipients age 21 or older, the ASA conducts the assessment to determine eligibility and authorize the plan of care. Providers who believe a significant change or service need assessment is needed **MUST** contact HCCA to authorize and request a reassessment. The 60-day appeal applies to initial assessments and the 10 and 60-day appeal applies to reassessments on consumers currently receiving services under this program.
- 13. Nursing Facility Assessment:** Assessment requested prior to admission to a nursing facility as a Medicaid applicant or for a redetermination (reassessment) of medical eligibility for continued Medicaid reimbursement. This could be triggered by service need, significant change or reassessment due. The 60-day appeal applies to initial assessments and the 10 and 60-day appeal

applies to reassessments. Consumers transferring from the hospital to SNF level of care who require Medicaid to pay 100% of the SNF stay for reimbursement because no Medicare or other third party payor is available **MUST** be assessed and determined medically eligible prior to admission to the SNF unit or facility. There are several categories of requests that are nursing facility assessments but fall under special funding or policy parameters. The following are those requests:

14. **20-day Medicare/Medicaid:** Person enters nursing facility under the Medicare benefit and requires nursing facility Medicaid financial assistance with the 20% copay and deductible beginning on day 21 of a skilled nursing facility stay. Valid eligibility classification is limited to the time period that Medicare continues to pay for the 80% cost of stay. Assessments are completed only when the Assessing Services Agency (ASA) has received notice from BFI that a Medicaid application has been filed for nursing facility Medicaid. This is considered an initial assessment and 60-day appeal applies. This is a time limited medical eligibility determination up to no more than 80 days of Medicare or other third party coverage for SNF level of care. Updates or conversions do not apply to this category of assessments. Please note that an Advisory plan is not applicable for this type of assessment. Consumers transferring from the hospital to SNF level of care who require Medicaid for reimbursement because Medicare or any other third party payor is not available **MUST** be assessed and determined medically eligible prior to admission to the SNF unit or facility.
15. **Medicare to Medicaid conversion:** If a person wants to stay in the nursing facility at the end of the Medicare benefit stay, (can be up to 100 days maximum), an assessment must be completed to determine medical eligibility for Medicaid to pay at the 100% level. The Assessing Services Agency (ASA) must have received notice from BFI that a financial nursing facility Medicaid application has been filed or the consumer must already be a nursing facility Medicaid recipient prior to the SNF stay. For consumers with Community Medicaid, for whom a BFI notice has not been received, who are requesting to stay in the NF, the assessment will be considered an initial and the outcome will be Advisory. The 60-day appeal applies to this type of initial assessment.
16. **20-day Medicare/ Medicaid to Nursing Facility Medicaid:** If a person wants to stay in the nursing facility at the end of the Medicare benefit stay, when a 20 day Medicare/ Medicaid copay assessment has been completed, an assessment must be completed to determine medical eligibility for Medicaid to pay at the 100% level. This is considered a reassessment because the initial assessment was completed on Day 20 or later during the Medicare stay and the 10-day and 60-day appeal applies because the person was a nursing facility Medicaid recipient for the copay and deductible.
17. **30-day Community Medicaid:** Community Medicaid provides up to **30 days** of nursing facility care without requiring that the recipient's financial eligibility be reviewed for nursing facility level of care. Eligibility is valid for only 30 days and the assessment expires unless the applicant has applied for a financial review. If notice is received from BFI of the financial review, a conversion assessment must be done to indicate continued medical eligibility. If a consumer appeals the outcome of a reassessment following a 30-day Medicaid eligibility period, Medicaid will **NOT** continue reimbursement to the nursing facility during the appeal because nursing facility Medicaid was **NOT** the reimbursement source. It was Community Medicaid. This assessment expires at the 30-day date. **This 30-day end date does not equate with reassessment date.** If the Assessing Services Agency (ASA) receives notice from BFI

that the consumer requested a financial change to NF Medicaid, the conversion of the original will be viewed as an initial NF assessment.

- 18. Advisory nursing facility assessment updated to Medicaid:** Person initially requests an assessment for admission to a nursing facility. Advisory medical eligibility is determined and is valid for up to 30 days. If the assessor receives notice within 30 days of the assessment date that a Medicaid financial application has been filed at BFI, and the consumer was determined medically eligible for NF, an update may be done. If the consumer was denied medical eligibility at the time of the Advisory assessment, a face-to-face reassessment, reimbursed by Medicaid must be completed within 5 days of receipt of the LTC message form. Person can be located in the home, hospital, out of state or the nursing facility. This is considered an initial assessment and only the 60-day appeal applies.
- 19. Advisory Medicare to Private Pay nursing facility:** If the person chooses to stay in the nursing facility and private pay at the end of the Medicare or other third party payor SNF stay in the nursing facility, an assessment must be completed to determine advisory medical eligibility, as mandated by State statute. **In these situations the mandated assessment has been deferred until the end of the SNF stay. In order to comply with the State statute an Advisory assessment must be completed. If the consumer chooses to remain in the NF or return home with services in place, after the SNF benefit ends an assessment MUST be completed.** Medical eligibility is advisory and valid for up to 30 days. **No appeal** to advisory assessment outcome. If the assessor receives notice within 30 days of the assessment date that a Medicaid financial application has been filed at BFI, an update may be done.
- 20. Continuing Stay Review:** Federal requirement for nursing facilities to review residents quarterly for “continued” medical need for nursing facility (NF) care. Nursing facilities cannot terminate medical eligibility. Nursing facility informs consumer that an assessment will be completed to determine continued medical eligibility for NF care. Nursing facility refers to Assessing Services Agency (ASA) for determination of medical eligibility for current Medicaid recipients. The 10 and 60-day appeal applies to reassessments and this is considered a reassessment of continued medical eligibility for NF care.
- 21. Extraordinary Circumstances to Nursing Facility Medicaid:** Medicaid currently paying for nursing facility care on a person who is not medically eligible. The nursing facility requests an assessment to determine medical eligibility based on a significant change in the consumer’s condition. For NFs who are requesting a significant change assessment, the referral should include the person’s last two MDS assessments with the referral request. One of the MDS assessments submitted must be a significant change MDS. The 10 and 60-day appeal applies to reassessments and this is considered a reassessment of medical eligibility for nursing facility care.
- 22. Katie Beckett:** An option for children under 18 to get services under Medicaid if they are determined medically eligible for nursing facility, psychiatric hospital or hospital level of care.
- 23. Nursing Facility Private Duty Nursing:** For 0 to 21 year olds who are current Medicaid recipients and are determined medically eligible for nursing facility care that they receive at home or in the community versus in a facility.

- 24. Congregate Housing Services Program:** People who want to access this program are assessed by the CHSP provider.
- 25. Brain Injury (TBI):** People who have an acquired brain injury who are in need of specialized services beyond nursing facility level of care. People must meet the nursing facility eligibility criteria **PLUS** additional criteria. Please refer to Section 67 for additional criteria.
- 26. Medicaid Home Health:** For consumers age 21 or older who are current Medicaid recipients and who require prior authorization of Medicaid Home Health services according to Section 40.02-3D.
- 27. PDN Medication Services:** Section 96.02-4D of the Maine Medical Assistance Manual allows for medication administration or monitoring services for a person who qualifies for the Community Support Services, Section 17, for Persons with Severe and Disabling Mental Illness. The Provider Agency may determine medical eligibility for this level of services.
- 28. PDN Venipuncture Only:** Section 96.02-4E of the Maine Medical Assistance Manual allows for venipuncture services when an individual requires only venipuncture services on a regular basis, as ordered by a physician. The Provider Agency may determine medical eligibility for this level of services.
- 29. Consumer Directed HBC:** Consumers 18 years and older who want to access the State funded consumer directed home based care program. The Authorized Agent who administers the consumer-directed programs completes the assessment and the authorized plan of care. Consumers must be determined cognitively capable to direct personal care services. If the assessment is completed by the Assessing Services Agency (ASA), the plan of care is Advisory only and the assessment is valid for 30 days. A copy of the completed MED form will be forwarded to the HCCA for consumer-directed programs. When there is a waiting list, consumer must be reassessed if their name comes up on the waiting list after 30 days from the assessment date. Services cannot begin until the consumer has successfully completed skills training and hired a personal care attendant. The assessment will then be converted and given 90-day eligibility from date of original assessment. Initial and reassessments are conducted according to policy. 10-day appeal applies to both initial and reassessments for this State funded program.
- A.7 Gender:** Enter "1" for Male or "2" for Female.
- A.8 Race/Ethnicity:** Ask the person what best describes their race or ethnic background. Enter the race or ethnic category within which the person places self. This is an optional question, which can be left blank if the person prefers not to answer.
- A.9 Birth date:** Use all boxes. For a one-digit month or day, place a zero in the first box. For example, January 2, 1918 should be entered as 01-02-1918.
- A.10.a Marital Status:** Choose the answer that best describes the person's current marital status.
- A.10.b. Citizenship:** Choose one answer from "1" U. S. Citizen, "2" Legal alien, or "3" Other.

A.11 Primary Language: Code for the language that the person primarily speaks or understands. Enter "0" for English, "1" for French, "2" for Spanish, or "3" Other for any language other than English, French, or Spanish. If the primary language is none of the 3 listed languages, specify the language in the space provided.

A.12 Current Income Sources for Applicant and Household: Check all sources of income for the person and the household. In order to determine whether application to Medicaid as a potential funding source is feasible, and should be checked in **A.13**, the assessor will have to inquire about person and household asset amounts and other pertinent financial information. The assessor will need to know annual household income, amount of personal assets, and person's income to determine potential reimbursement sources. Household income is utilized when cost-sharing is calculated for some State funded programs. **The assessment will be considered incomplete if these boxes are not completed.** Actual financial information collected from the consumer SHOULD not be documented in this box. It is a 'check off the box' field to indicate the income sources and whether the assets are greater than \$2000.00 for the applicant and/or household members. The form was designed to prevent the sharing of confidential financial information with anyone who received a copy of the completed MED form. The appropriate form for documentation of financial information is the financial assessment form and in most cases should be used to review and document financial information so the consumer receives the best outcome based on both their medical and financial status.

[Note: RE: A.12, refer to APPENDIX A for information on nursing facility financial eligibility, transferring assets, and Medicaid estate recovery. Refer to APPENDIX B, C and D for information on financial eligibility criteria for individuals in a nursing facility or at home under the Elderly Waiver or Adults with Disabilities Waiver.]

A.13 Current or Potential Payment Source: Please code a response in each box for the current or potential payment sources for long-term care services needed. Identify the primary payor for the program the person is considering (e.g., elderly waiver, nursing facility, home-based care). Include all payment sources that are viewed as potential sources of reimbursement for the services necessary to meet the person's needs. Then, further determine if Medicare may also be a reimbursement source in the setting being considered. Refer to the appropriate programs for information on their financial eligibility requirements. For item j (other), code with a "0" if the payment source is not used. This includes private pay and refers to the client's income and assets as the first payor source, after Medicare, for long-term care services.

The code in each box will reflect a verified eligibility, anticipated eligibility, or 'not eligible' payment source for the consumer.

EXAMPLES:

Record "0" if, based on income and/or asset information, financial eligibility for Medicaid seems not indicated.

If the consumer has a valid Community Medicaid card then "1" for eligible should be recorded in 13a. If a definite financial eligibility determination has not been made, but an application has been filed with BFI, as with any receipt of a LTC message form (123), 13b, 13c or 13d should be "2" for eligibility pending.

If an assessment is done and the consumer is medically eligible for the waiver and you anticipate the consumer to be financially eligible with the information given to you, you would put a “3” for eligibility anticipated in 13b or 13c

Unknown should only be used if you are unable to get any financial information from the consumer or responsible party. Another example when “4” is the appropriate code may be when the information is so unclear that the assessor cannot make an educated determination as to what financial category might be appropriate. Be sure to offer outreach services to assist the consumer with completion of a Medicaid financial application and alert the HCCA that outreach services are recommended.

Remember that all consumers denied waiver services based on medical eligibility are not automatically eligible to continue to receive a Medicaid card. **Do not rely on BFI to confirm a waiver consumer’s continued Community Medicaid eligibility at the time of the reassessment.** BFI needs to receive the denial of medical eligibility outcome for NF level or waiver care to begin the review of continued financial eligibility. Thus until BFI receives the outcome of the assessment you are completing, BFI will not be aware that medical eligibility has been denied and the hotline will provide you with erroneous information. Use 13 “b” for the Elderly and ADW Waiver recipients and “c” for the Physically Disabled Waiver recipients.

0. **Not eligible** - The person is not financially eligible for this program and financial eligibility is not anticipated at this time.
For item **j (other)**, code with a "0" if the payment source is not used.
1. **Eligible** - The person is financially eligible for this program or insurance. Eligibility refers only to the applicant's financial eligibility to be on the program.
For item **j (other)**, code with a "1" if other payment source (such as 3rd party, long-term care insurance, private pay) is used.
2. **Eligibility pending** - An application has been filed at the BFI regional office for this program or insurance. A determination of financial eligibility has not been reached as of the assessment start date.
3. **Eligibility anticipated** - An application has not been filed, but based on initial financial information collected, eligibility is anticipated and the application will be filed.
4. **Unknown** - Financial eligibility is unknown for this payment source.
[Note: This coding differs from the MDS 2.0 coding.]

- A.14 A. Location at Time of Assessment & B. Usual Residence:** Enter the corresponding number for the location of the person on the assessment start date. Also enter corresponding number for Usual Place of Residence.
- A.15 Usual Living Arrangement:** Check all appropriate boxes for who lives with the person at his/her current residence. If person is being assessed for nursing facility eligibility while at the hospital, check appropriate box for his/her residence prior to hospitalization.
- A.16 Number in Household (incl. applicant):** Enter the number of people who live in the applicant's household including the person. For those applicants who live in an institution or residential care facility, enter ‘01’ in the boxes.
- A.17 Responsibility/Legal Guardian:** Before completing this item, be sure that you are familiar with the following information. Check all that apply.

A Primer on Powers of Attorney, Guardianship and Related Issues for Long Term Care Assessors

Among consumers of long-term care, there are frequently legal arrangements such as durable powers of attorney and guardianship. These legal arrangements may affect who makes the choice of what kind of care the person will receive, as well as who has access to information. It is important for people working in the long term care field to understand the subtle differences between these different kinds of arrangements, in order to ensure that both consumer's right of choice is preserved and that informed choices are made.

Powers of Attorney A power of attorney is a document in which one person (called the principal) gives another person (called an agent or attorney-in-fact) the power to make decisions or handle transactions on his or her behalf. If the document is not a durable power of attorney, it does not continue in effect after the principal becomes incapacitated.

A **durable power of attorney** is a power of attorney, which continues in effect after the principal becomes incapacitated. Its purpose is to ensure that there will be an agent in place to act on the principal's behalf after the principal becomes incapacitated. The powers of attorney seen in the long-term care context will usually be durable powers of attorney. A durable power of attorney will include the following kind of language: "This power of attorney shall continue in effect following the incapacity of the principal," or "This power of attorney shall become effective upon the principal's incapacity."

Durable powers of attorney may delegate authority to make financial decisions, health care decisions, or both. Depending on the wording, the powers granted may be comprehensive or they may be limited and specific in scope. In addition, some durable powers of attorney are effective from the moment they are created, while others do not grant any authority to the agent unless certain events occur (for example, until the principal's physician certifies that the principal is no longer able to make his or her own decisions).

Because durable powers of attorney vary in scope, assessors and others should read the power of attorney from start to finish in order to ascertain whether the agent has authority to access information on the consumer's long term care status and to participate in choices about care. It may be necessary, from time to time, to consult legal counsel about the scope of authority under a durable power of attorney.

Durable powers of attorney are attractive to people because they are private and do not require the approval or involvement of a court. (Contrast Guardianship, below.) **Even more important, the durable power of attorney allows the person to exercise choice and remain in control for as long as possible. When the principal executes a durable power of attorney, s/he is not giving up her right to make her own decisions. Rather, the principal is appointing a kind of deputy, who makes decisions when s/he is unable to. This means that the principal still has the right to receive notices, assessments, and other relevant information concerning eligibility and health care issues generally. Notices should be sent to both the principal and the agent. The principal also retains the right to make his or her own choice regarding the type of care to be received and the setting in which to receive it. If the principal and agent disagree concerning this choice, the principal's decision governs.**

This can be troubling to assessors, care providers and others, when the principal appears to be impaired mentally and makes choices that may, in the opinion of others, endanger him or her. There may even be a written opinion from a doctor or other clinician that the person is incapacitated. Nevertheless, if the principal has not been found by a court to be incapacitated, assessors, providers and others should continue to inform the person concerning the consumer's long term care status and to involve the person in decision making. Depending on the circumstances, a referral might be appropriate to adult protective service. The result may ultimately be that a guardian is appointed to override the power of attorney and make informed decisions on the consumer's behalf.

A person has the right, after executing a power of attorney, to revoke the arrangement. When this happens, assessors should from that point on send notices only to the person and stop sending notices to the agent, who no longer has a legal right to receive such notices. Again, where there is concern that the person is in fact incapacitated and not making informed choices, a referral could be made to adult protective services.

Guardianship A guardian is a person appointed by the probate court to make health care, residential and other personal decisions for another person (called a ward) who is found by the court to be incapacitated. A guardian has a similar kind of authority as a parent has over a minor child. Under full guardianship, the ward loses the right to make his/her own decisions. (Contrast Powers of Attorney, above.)

Some guardianships are limited guardianships. This means that the guardian can only make certain kinds of decisions for the ward. The ward continues to make her own decisions in other areas of her life. An example is a guardianship under which the limited guardian is permitted to make medical decisions for the ward but not decisions concerning placement.

It is important that assessors and others, faced with a situation in which the person has a guardian, ask to see the court papers that describe the scope of the guardianship. Either the "Adjudication of Incapacity" or the "Letters of Guardianship" should be reviewed. These should be made available by the guardian, but can also be obtained from the probate court. The guardianship order may not allow the guardian to make decisions about long term care and placement choices.

Generally, assessors should send notices to both the guardian and the ward. An exception should be made where the guardian expresses concern that such notices will be harmful to the ward (for example, by causing agitation) and asks that notices be sent only to the guardian.

Related Issues There are several other types of legal arrangements which are seen in long-term care settings that assessors and others should understand. These arrangements, while useful for some purposes, do not authorize people other than the principal to make long term care choices for themselves.

A **living will** is a document which states what type of care the person wants to receive if s/he is in a terminal condition and unable to express his or her own wishes. The living will may name another person to make decisions about terminal care. This document, without more, does not authorize the person to make other kinds of choices for the person, including placement.

A **representative payee** is a person appointed by Social Security, Veterans Administration or another federal agency to handle the monthly benefit check for a recipient who is found by the

agency to be unable to manage the benefit responsibly. The payee has no authority with respect to other finances and property and no authority to make long term care or placement choices.

A **conservator** is a person appointed by the probate court to make financial and property decisions for a person who is found by the court to be incapacitated. This is similar to guardianship, but applies only to money and property. A conservator who is not a guardian or holder of a durable power of attorney for health care does not have authority to make placement and long term care decisions for the person.

A.17 Responsibility/Legal Guardian: Check only those items with available documentation that indicate someone else is responsible for participating in legal decisions about the consumer's **health care and treatment.**

- a. **Legal Guardian:** Guardians are appointed after a court hearing and are authorized to make decisions that include giving and withholding consent for medical treatment. Once appointed, the decision-making authority of the guardian may be revoked only by another court hearing.
- b. **Other Legal Oversight:** Any other program in the state whereby someone other than the person participates in or makes decisions about the consumer's health care and treatment, e.g., conservator, temporary guardian, or financial POA.
- c. **Durable Power of Attorney/Health Care Proxy:** Documentation that someone other than the consumer is legally responsible for the consumer's legal affairs, or for health care decisions if the person becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the consumer's wishes for care. [**Note: Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked by the person at any time.**]
- d. **Family Member:** Includes immediate family or significant other(s) as designated by the person. Responsibility for decision-making may be shared by both the person and the family.
- e. **Applicant:** Consumer retains responsibility for decisions. In the absence of guardianship or legal documents indicating that decision-making has been delegated to others, assume that the person is the responsible party.
- f. **Other:** If the individual has financial or other restrictions, with supporting documentation, not indicated elsewhere.
- g. **Unknown:** Legal guardianship or responsibility for the consumer's **health care and treatment** is unknown.

A.18 Advanced Directives: Federal law requires that people be told about their right to make decisions about their health care choices. * The medical record in the nursing facility or hospital setting includes the necessary information to determine what category to check. AAA's have available a comprehensive record of information on most of the people they serve. All health care providers are required to ask people about their preferences and should be knowledgeable and comfortable in discussing these basic issues as professional health care providers. If assessing in the community and no advanced directives are available, the options need to be explained to the person as mandated by Federal law, and information should be made available to him or her. **Health Care Advanced Directives: Your Right To Choose**, which is available through BEAS, includes information to assist people in making a decision about a living will or advanced directive. Familiarize yourself with the legal status of each type of directive. Review medical records, when available, for written documentation verifying the existence and nature of

these directives. Documentation must be available in the record for a directive to be considered current and binding. Check all items that apply and have supporting documentation available. If there are no advanced directives or none are verified by documentation, check **i. None of Above**.

[*Note: See Appendix E for information on the Patient Self-Determination Act.]

- a. Living Will:** A document specifying person's preferences regarding measures used to prolong life when there is a terminal prognosis. It may specify that no heroic measures be used to prolong life when there is a terminal prognosis.
- b. Do not resuscitate orders:** In the event of respiratory or cardiac failure, the person or family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore respiratory or circulatory function.
- c. Do not hospitalize order:** A document specifying that person is not to be hospitalized even after developing a medical condition that usually requires hospitalization.
- d. Organ donation:** Instructions indicating that person wishes to make organs available for transplantation upon death.
- e. Autopsy request:** Document indicating that the person or family or legal guardian has requested that an autopsy be performed upon death. **[Note:** The family must still be contacted prior to performing the procedure.]
- f. Feeding restrictions:** Consumer or family or legal guardian does not wish the person to be fed by artificial means (e.g., tube, intravenous nutrition) if unable to be nourished by oral means.
- g. Medication restrictions:** Consumer or family or legal guardian does not wish the person to receive life-sustaining medications (e.g., antibiotics, chemotherapy) **[Note:** These restrictions may not be applicable, however, when these medications are used to ensure the consumer's comfort.]
- h. Other treatment restrictions:** Consumer or family or legal guardian does not wish the person to receive certain medical treatments. Examples include, but are not restricted to, blood transfusion, tracheotomy, respiratory intubation, and restraints. **[Note:** These restrictions may not relate to care given for palliative reasons, such as reducing pain, or distressing physical symptoms, such as nausea or vomiting.]
- i. None of Above:** If none of above directives apply or can not be verified by documentation in the medical records, check None of Above.

A.19 Contacts: Enter names and addresses of people who can be contacted in the event of emergency involving the person. List their telephone numbers and relationship to the person. Also, check whether that person is a legal guardian.

A.20 Referring/Continuing Physicians: List names, addresses, and phone numbers of both the referring physician and the continuing physician.

Homebound Status:

Enter 0 or 1 for homebound status: No/Yes. Homebound status equals "Yes" if the physician has certified that the consumer is homebound or meets the homebound exemption criteria found in Section 40 of the Medicaid Home Health rules of the Maine Medical Assistance Manual.

CLINICAL DETAIL (Page 1 of 5)

Clinical Detail is the eligibility determination part of the MED. The assessor is able to determine eligibility upon completion of **Clinical Detail** for multiple programs at home and for admission to an institution. Requirements for submission to the Department for classification vary among the various Medicaid programs. Please refer to the appropriate policies and regulations. All items that relate to the consumer's medical care needs and ability to function are assessed in this section.

Completion of the MED may require review of documentation in the medical record if the person is assessed in an institution. If the person is in the community, the assessor will need to ask the person, family members, or formal and informal caregivers to determine whether varying levels of assistance have been provided at different times of the day within the past 7 days.

Skilled nursing services identified may cue the assessor to the appropriate reimbursement source for care.

Clinical Detail Header includes the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #, and Assessment Date.** THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE.**

AGENCY NAME/PROVIDER-ASSESSOR #: Enter the agency/organization name responsible for completing the MED assessment form and the agency/organization's 9-digit Medicaid provider number. Use all boxes for the Medicaid provider number.

APPLICANT NAME/SOCIAL SECURITY #: Enter the person's name and his/her 9-digit social security number. Use all the boxes for the social security number.

ASSESSMENT DATE: Enter the date the MED assessment was started. This date is identical to the date entered as **Assessment Start Date** on Background Information page. Use all boxes. For a 1-digit month or day, place a zero in the first box; e.g., July 2, 2001 should be entered as 07-02-2001.

CLINICAL DETAIL: DEFINITIONS

New/recent means within 30 days of assessment date.

Unstable- a medical condition is **unstable** when it is fluctuating in an irregular way and/or is deteriorating and affects the consumer's ability to function independently. These changes must require medical treatment and professional nursing observation, assessment and management at least once every 8 hours. The change or decline in physical health requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medications. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. **Not** included is the loss of function resulting from a temporary disability from which full recovery is expected.

Significant change-A “significant change” in status is defined as a major change in the person’s status that: is not self-limiting; impacts on more than one area of the person’s functional or health status; and requires interdisciplinary review and/ or revision of the care plan. A significant change assessment may be requested if a change is consistently noted in two or more areas of decline, or two or more areas of improvement and the significant change impacts on the eligibility outcome.

Decline:

- Any decline in ADL physical functioning where a person is newly coded as 3, 4, or 8 (Extensive assistance; Total dependency; Activity did not occur).
- Increase in number of areas where Behavioral symptoms are coded as not easily altered (increase in number of code 1’s)
- Person’s decision making changes from 0 or 1 to 2 or 3.
- Emergence of a condition/ disease in which person is judged to be unstable.
- Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at that stage or higher.
- Overall deterioration of person’s condition; person receives more support, (e.g., in performing ADLs, or in decision making).

Improvement:

- Any improvement in ADL physical functioning where a person is newly coded as 0, 1, or 2 when previously scored as 3, 4, or 8.
- Decrease in number of areas where Behavioral symptoms of Section D1.a. -1.e. are coded as not easily altered.
- Person’s decision making changes from 2 or 3 to 0 or 1.
- Person’s incontinence pattern changes from 2, 3, or 4 to 0 or 1.
- Overall improvement of person’s condition; person receives fewer supports.

Note: this is not an exhaustive list

SECTION A. PROFESSIONAL NURSING SERVICES

Code for each condition/treatment for which the person will need care that is or otherwise would be provided by or under the supervision of a registered professional nurse. If the person is in a hospital, identify person's needs at point of discharge. Use the following codes for Section A.1 - A.10. Every block must be coded with a response. If a treatment or procedure is self-administered and the consumer is independent in the task, do not score as a nursing need to be done by another person. Score with a ‘0’ for independent, when professional nursing, monitoring is not required.

0. Conditions/treatment not present in the last 7 days.
1. 1-2 days a week.
2. 3-4 days a week.
3. 5-6 days a week.
4. 7 days a week.
5. Once a month
6. **Used for Extended PDN only:** At least once every 8 hours/7 days a week

- A.1 Injections/IV feeding-** Person will need care that is or otherwise would be performed by or under the supervision of a registered nurse for injections (intraarterial, intravenous, intramuscular or subcutaneous) or IV feeding for the treatment of an unstable condition requiring medical or professional nursing intervention, excluding daily insulin injections for a person whose diabetes is under control. A diabetic's condition is considered to be controlled when his/her blood sugar is maintained at a level that is considered within normal limits for that individual and requires no adjustment of the maintenance dose of insulin. **Every box must be coded with a response.**
- A.2 Feeding tube-** Person will need care that is or otherwise would be performed by or under the supervision of a registered nurse for a feeding tube (nasogastric, gastrostomy or jejunostomy tube) for a new/recent (within 30 days) or an unstable condition. **Every box must be coded with a response.**
- A.3 Suctioning/Trach care-** Person will need care that is or otherwise would be performed by or under the supervision of a registered nurse for deep nasopharyngeal suctioning or tracheostomy care for a new/recent (within 30 days) or an unstable condition. **Every box must be coded with a response.**
- A.4 Treatment/Dressing-** Person will need care that is or otherwise would be performed by or under the supervision of a registered nurse for the treatment and/or application of dressings when the physician has prescribed irrigation, application of prescribed medication, or sterile dressings of stage 3 or 4 decubitus ulcers, other widespread skin disorders (except psoriasis or eczema), or care of wounds, including but not limited to ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites and tumor erosions. Physician ordered daily chest physical therapy, by the professional nurse, to support respiratory status for an acute episode of disease process. If the chest physical therapy is provided by a respiratory therapist code in the A.11. The following examples are EXCLUDED: peri rash, reddened coccyx, non-barrier dressings for Stage 1 and 2 ulcers, steristrips, and healed tube sites. **Every box must be coded with a response.**
- A.5 Oxygen-** Person will need care that is or otherwise would be performed by or under the supervision of a registered nurse for administration of oxygen on a regular and continuing basis when his/her condition warrants professional observation for a new/recent (within 30 days) condition. **A response must be coded.**
- A.6 Assessment/management-** Person will need professional nursing assessment, observation and management for an **unstable medical condition** (see previous definition) that because of exacerbations or episodes warrants and requires professional nursing intervention for assessments, monitoring, and management. **Observation must be needed at least once every 8 hours (once per shift), throughout a 24 hour period.**
- A.7 Catheter-** Person will need care that is or otherwise would be performed by or under the supervision of a registered nurse for the insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition. The need for the catheter must be documented and justified in the medical record. Examples include, but are not limited to, installation for the treatment of cancer of the bladder or as

adjunctive treatment for wound or decubitus healing. If a person at home has a catheter, the assessor will need to check with the person, family, MD, or home health agency to determine why the catheter is being used. For example, if a bedridden person with a bedsore has a catheter to prevent further skin breakdown, the skin breakdown prevention and treatment qualifies as a medical need, but the catheter's use to manage incontinence for the convenience of the caregiver does not qualify as an adjunct to active treatment of disease or medical condition. **A response must be coded.**

[Note: catheters as a method of managing incontinence are considered in Clinical detail, Section E Physical Functioning/Structural Problems: f. Toilet Use. The above example **does** meet the toileting need addressed in Section E and would be coded with a "2" or "3" for self-performance and "2" for support.]

- A.8 Comatose-** Person will need care that is or otherwise would be performed by or under the supervision of a registered nurse to manage a comatose condition. A person is considered comatose when in a state of unconsciousness from which he or she cannot be aroused; i.e., **persistent vegetative state**, or has a neurological diagnosis of **coma**. **A response must be coded.**
- A.9 Ventilator/Respirator-** Person will need care that is or otherwise would be performed by or under the supervision of a registered nurse to manage the ventilator/respirator equipment. **A response must be coded.**
Ventilator or Respirator- assures adequate ventilation in person who is, or who may become, unable to support his/her own respiration. Include any type of electrically or pneumatically powered closed system mechanical ventilatory support device.
[Note: CPAPS and BIPAPS are not ventilators.]
- A.10 Uncontrolled Seizure Disorder-** Direct assistance from others is required for the safe management of an uncontrolled seizure disorder (i.e., grand mal). An "uncontrolled seizure disorder" is defined as a "diagnosed seizure disorder that cannot be managed by medications." The physician is the best person to make this judgment. **A response must be coded.**
- A.11 Therapy/therapies provided by a qualified therapist-** Enter the number of days per week required for physical therapy, speech/language therapy, occupational therapy or respiratory therapy provided or directed by a qualified therapist. This item pertains only to therapies prescribed and being received, with goals, time frames, and a physician order. Enter "0" if none needed. To be considered, a therapy must meet the following criteria:
0. Finding of initial evaluation and reassessments must be documented in the recipient's medical record.
 1. Skilled therapeutic services must be ordered by a physician and designed to achieve specific goals within a given time frame.

Palliative or maintenance therapy is excluded: for example, respiratory therapy must be done by a respiratory therapist. If therapy is not ongoing or has not been ordered as part of the treatment plan, then this section probably will not be applicable. Enter "0" if none needed.

Sum the days per week required for each therapy and indicate total number of days of therapy per week in box. **A number (0-7) must be entered in the box.**

- A.12 Therapy/therapies-** Is therapy required at least once a month for any of the following: physical, speech/language, occupational, or respiratory therapy? Code "0" if no, code "1" if yes. If A.11, Therapies-Total is greater than "0" for number of days of therapy per week, then A.12 = "1", therapy required at least once a month.
- A. 13 Assessment/management-** Person needs professional nursing assessment, observation and management for a stable or chronic medical condition that warrants and requires professional nursing intervention for assessments, monitoring, and management at least once a month. Specify the condition if applicable. Code "0" if no, code "1" if yes.

SECTION B. PROFESSIONAL NURSING SERVICES/SPECIAL TREATMENTS AND THERAPIES

The following codes are used for those post operative or chronic conditions that require professional nursing care and monitoring for administration of treatments, procedures, or dressing changes which involve prescription medications, according to physician orders. **Code for the number of days care would be performed by or under the supervision of a registered professional nurse.**

0. Not required
1. 1-2 days/week
2. 3 or more days/week
3. Once a month

[Note: Intermittent RN care (monthly or weekly) does NOT meet the minimum nursing facility eligibility requirements of Section 67.02-3.]

B.1 Treatments/Chronic Conditions-

Professional nursing care and monitoring for the administration of treatments, procedures, or dressing changes which involve prescription medications for post-operative or chronic conditions according to physician orders. Please specify. Physician orders for treatments, procedures, or dressing changes should be reflected on the order sheet. **EXCLUDED** are: proper positioning of patients in bed, wheelchair or other accommodations; bed baths; prevention and treatment of skin irritations and non-barrier dressings for Stage I and II decubitus ulcers; observation of vital signs and detailed recordings of findings in person's record; assistance and training in self-care as required for feeding, grooming, ambulation, toilet activities and other activities of daily living; and assistance and training in person transfer techniques, administration of routine medications, performance of routine care for a person, (i.e., incontinence; prophylactic and palliative skin care including bathing and applications of creams and/or treatment of minor skin problems; routine care in connection with casts, braces, and other devices; instruction in basic health needs; and change of dressings for non-infected post-operative or chronic conditions.) **Each box must be coded with a response.**

- a. Medications via tube** Any medication ordered by a physician that can only be administered via a gastrostomy, jejunostomy or naso-gastric tube for a person who cannot do this for themselves. This must be done by an RN or a family/friend who has been taught to perform this skill that would otherwise require the skills of a licensed nurse.
- b. Tracheostomy care, >30 days old and stable** Includes cannula care, trach dressing changes and suctioning related to the routine daily tracheostomy care for people who cannot do this for themselves. This must be done by an RN or a family/friend who has been taught to perform this skill that would otherwise require the skills of a licensed nurse.
- c. Urinary Catheter change** Removal and reinsertion of a new urinary catheter for people who cannot do this themselves. This must be done by an RN or family/friend who has been taught to perform this skill that would otherwise require the skills of a licensed nurse. If the person performs this task independently, then it cannot be counted and would be coded “0” -professional nursing care and monitoring not required.
- d. Urinary catheter irrigation** This includes the “flushing” of a urinary catheter to prevent or remove a deposit that prevents the drainage of urine. This must be done by an RN or a family/friend who has been taught to perform this skill that would otherwise require the skills of a licensed nurse. If the person performs this task independently, then it cannot be counted and would be coded “0” -professional nursing care and monitoring not required.
- e. Venipuncture by RN** This is the drawing of blood from a person to be sent to a lab for doctor ordered lab studies to monitor the person’s condition or response to treatment. PDN policy allows venipuncture by a Licensed Practical Nurse. Use this box to indicate venipuncture being done by either a LPN or RN.
- f. Monthly injections** The administration of a doctor ordered medication on a monthly basis via an intramuscular route. This must be done by an RN or a family/friend who has been taught to perform the injection that would otherwise require the skills of a licensed nurse. If the person performs this task independently, it cannot be counted and would be coded “0” -professional nursing care and monitoring not required.
- g. Barrier dressings for Stage I or II ulcers** These dressings are occlusive dressings used to treat and/or debride Stage I or II decubitus ulcers. The assessment skills of a licensed nurse are required to monitor the affects of the treatment and to adjust or change the treatment plan in consultation with a physician. This must be done by an RN or a family/friend who has been taught to perform this skill that would otherwise require the skills of a licensed nurse. If the person performs this task independently, then it cannot be counted and would be coded “0” -professional nursing care and monitoring not required.
- h. Chest PT by RN** This is chest physical therapy for a chronic condition where the PT provides preventative/maintenance airway clearance such as in the case of a person afflicted with cystic fibrosis. This must be done by an RN or a family/friend who has been taught to perform the PT that would otherwise require the skills of a licensed nurse.
- i. O₂ therapy by RN for chronic unstable condition >30 days old** This is the treatment of a process where the person has been diagnosed but continues to need the assessment and management of the RN to maintain respiratory status. This must be done by an RN or a family/friend who has been taught to assess and monitor therapy that would otherwise require the skills of a licensed nurse.

j. Other Please specify ‘other’ condition for which treatment is done by an RN or a family/friend who has been taught to perform this skill that would otherwise require the skills of a licensed nurse.

B.2 Treatments/Procedures

Code for the number of days professional nursing is required for physician-ordered chemotherapy, radiation therapy, or dialysis.

0. Not required
1. 1-2 days/week
2. 3 or more days/week
3. Once a month

Every box must be coded with a response.

- a. Chemotherapy:** Any type of chemotherapy (anticancer drug) given intravenously or by injection.
- b. Radiation therapy:** The treatment of disease by ionizing radiation.
- c. Hemodialysis:** A method for removing unwanted byproducts from the blood of persons with renal insufficiency or failure through the use of a machine (dialyzer).
- d. Peritoneal Dialysis:** Peritoneal dialysis (CAPD) is a method of removing unwanted byproducts from the body through the instillation of dialysate into the peritoneal cavity and using the abdominal wall as a filter.

CLINICAL DETAIL: (p.2 of 5)**CLINICAL DETAIL HEADER**

Clinical Detail Header includes the following items: **Agency Name, Provider-Assessor #, Assessment Date, Applicant Name, and Applicant Social Security #**. THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE**.

Questions about cognitive function and memory can be sensitive issues for some people who may become defensive or agitated or very emotional. These are not uncommon reactions to performance anxiety and feelings of being exposed, embarrassed, or frustrated if the person knows he or she cannot answer the questions cogently.

Be sure to interview the person in a private, quiet area without distractions, i.e., not in the presence of other people or family, unless the person is too agitated to be left alone. Using a nonjudgmental approach to questioning will help create a needed sense of trust with the person. After eliciting the person's responses to the questions, turn to the direct staff caregiver(s) for the person (or the person's family or others, as appropriate) to clarify or validate information regarding the person's cognitive function over the last seven days.

- Engage the person in general conversation to help establish rapport.
- Actively listen and observe for clues to help you structure your assessment. Remember that repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide important information about cognitive function.
- Be open, supportive, and reassuring during your conversation with the person (e.g., "Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you").

If the person becomes really agitated, sympathetically respond to his or her feelings of agitation and STOP discussing cognitive function. The information-gathering process does not need to be completed in one sitting but may be ongoing during the entire assessment period. Say to the agitated person, for example, "Let's talk about something else now," or "We don't need to talk about that now. We can do it later." Observe the person's cognitive performance during the interview.

SECTION C. COGNITION

C.1 Memory- determines the person's capacity to remember both recent and long-past events. **Use the following codes for section C.1a. and 1.b. Each box must be coded with a response.**

- 0. Memory OK
- 1. Memory problems

C.1.a. Short-term memory- ask the person to describe a recent event that you both had the opportunity to remember or use a more structured short- term memory test. Examples: ask person to describe his/her most recent meal. Name 3 items (e.g., book, watch, table). Immediately after you state the items, have person repeat them to verify understanding. Continue other conversation. After 5 minutes, ask person to repeat the names of the items again. If s/he cannot, code "1."

Example for 1.a

Ask the person to describe the breakfast meal or an activity just completed.

C.1.b. Long-term memory- engage in conversation that is meaningful to the person. Ask questions for which you already know the answers (e.g., from your review of record, general knowledge, family). Examples: you may use questions such as the following. Have you ever lived somewhere else? What was your address? Are you married? Do you have any children? How many? When is your birthday? If person cannot answer this type of question, code "1."

Example for 1.b

Ask the person, "Where did you live just before you came here?" If "at home" is the reply, ask, "What was your address?" If "a nursing home" is the reply, ask, "What was the name of the place?" Then ask: "Are you married?" "What is your spouse's name?" "Do you have any children?" "How many?" "When is your birthday?" "In what year were you born?"

C.2 Memory/Recall Ability- To determine the person's memory/recall performance within the environmental setting. A person may have intact social graces and respond to family and others with a look of recognition yet have no idea who they are. This item will enable the assessor to probe beyond first, perhaps mistaken, impressions.

Purpose: Test memory/recall. Use information obtained from clinical records or from family and formal and informal caregivers. Ask the person about each item. For example, "What is the current season? "What is the name of this place?" "What kind of place is this?" If the person is not in his or her room, ask "Will you show me to your room?" Observe the person's ability to find the way.

For each item that the person can recall **during the last 7 days (or if in a hospital, during the last 24-48 hours), check the corresponding answer box.**

C.2.a. Current season- able to name the current season (e.g., correctly refers to weather for the time of year, legal holidays, religious celebrations).

C.2.b. Location of own room- able to locate and recognize own room. He or she should be able to find the way to the room.

C.2.c. Names/faces-able to distinguish family members, friends, caregivers, and strangers. **Note: This language is different from the MDS 2.0 language.**

C.2.d. Where he/she is- able to distinguish where person is (e.g., home, hospital, nursing home). **Note: This language is slightly different from the MDS 2.0 language.**

C.2.e. None of the above were recalled.

C.3 Cognitive Skills for Daily Decision Making- determines the person's ability to make everyday decisions about the tasks or activities of daily living. If the person is in a nursing facility, review the clinical record. Consult family and formal and informal caregivers. Observe the person during the assessment interview. *The inquiry should focus on whether the person is actively making these decisions, and not whether a family member or caregiver believes the person might be capable of doing so.* Remember the intent of this item is to record what the person is doing (performance). Where a family member, or formal caregiver takes decision-making responsibility away from the person regarding tasks of everyday living, or the person does not participate in decision-making, whatever his or her level of capability may be, the person should be considered to have impaired performance in decision-making. This item is especially important for further assessment and care planning in that it can alert providers of care to a mismatch between a person's abilities and his or her current level of performance, or that family and/or caregiver may be inadvertently fostering the person's dependence.

Examples

Choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary); making the correct decision concerning how to get to the lunchroom; acknowledging need to use a walker, and using it faithfully.

Enter one number that corresponds to the most correct response. **Use the following codes:**

0. **Independent-** decisions consistent, reasonable and safe (reflecting lifestyle, culture, values); person organizes daily routine and makes decisions in a consistent, reasonable and organized fashion.
1. **Modified Independence-** person organizes daily routine and makes safe decisions in familiar situations, but experiences some difficulty in making decisions when faced with new tasks or situations.
2. **Moderately Impaired-** person's decisions are poor; person requires reminders, cues, and supervision in planning, organizing and conducting daily routines.
3. **Severely Impaired-** person's ability to make decisions is severely impaired; person never (or rarely) makes decisions.

C.4A Is professional nursing assessment, observation and management required at least 3 days/week to manage all the above cognitive patterns? Code "0" if no, code "1" if yes.

If C.4A = "yes," proceed to C.5. Do NOT complete the Supplemental Screen for Cognition.

If C.4A = "no," **and person meets the cognitive impairment threshold** as defined below, then go to Page 2A and complete Section C.4B Cognition.

A "threshold" score for "cognition" is equal to a score of "1" for loss of short-term memory and "2" of items A-D or E "none" for memory / recall ability and a score of "2" or "3" for cognitive skills for decision-making per Chapter II, Section 67 of the Maine Medical Assistance Manual.

If the cognitive impairment threshold is met and the person does not need nursing assessment at least 3 days a week, the Supplemental Screen for Cognition must be completed.

C.5 Is professional nursing assessment, observation and management required less frequently than 3 times per week but at least once per month? Code "0" if no, code "1" if yes. **Enter the one number that corresponds to the correct response to this question.**

CLINICAL DETAIL: SUPPLEMENTAL SCREENING TOOL (p.2A of 5)

CLINICAL DETAIL HEADER includes the following items: **Agency Name, Provider-Assessor #, Assessment Date, Applicant Name, and Applicant Social Security #.** THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE.**

SUPPLEMENTAL SCREENING TOOL Section C.4.B COGNITION.

Complete this cognitive screen only if the response to C.4A. is 0 "no" AND the person meets the cognitive impairment threshold. A "threshold" score for "cognition" is equal to a score of "1" for loss of short-term memory and "2" of items A-D or E "none" for memory / recall ability and a score of "2" or "3" for cognitive skills for decision making per Chapter II, Section 67 of the Maine Medical Assistance Manual.

Section C.4B. COGNITION. Enter the code that most accurately describes the person's cognition for the last 7 days.

1. Memory for Events: Enter the number that best describes person's recall of events/names within the last 7 days: 0, 1, 2, or 3.

2. Memory and Use of Information: Enter the number that best describes person's ability to remember and use information appropriately within the last 7 days: 0, 1, 3, or 4.

3. Global Confusion: Enter the number that best describes person's degree of confusion within the last 7 days: 0, 1, 2, or 3.

4. Spatial Orientation: Enter the number that best describes person's orientation to environment within the last 7 days: 0, 1, 2, or 3.

5. Verbal Communication: Enter the number that best describes person's ability to convey information within the last 7 days: 0, 1, 2, or 3.

C.4B. Total Cognitive Score: Add the answers to questions 1-5 and enter this number in the box provided. **Return to Section C5 on page 2.**

SECTION D. PROBLEM BEHAVIOR

Problem behaviors are those that cause distress to the person, or are distressing or disruptive to family members, caregivers, other residents, or staff. Such behaviors include those that are potentially harmful to the person or disruptive in the environment, even if staff and other residents, or family and caregivers appear to have adjusted to them (“Mrs. L. doesn’t mean to hit me. She does it because she’s confused.”). An example that may not warrant coding is Mr. Smith’s cursing. His family explains that this is how he has talked all his life. It is not a problem or change in behavior, nor is it directed at others. It has always been part of his personality and is considered “normal” for him.

Column A describes the frequency of these behaviors in the last 7 days and Column B describes the Alterability of these behaviors. Assessors should be alert to the possibility that family and formal and informal caregivers might not think to report a behavioral symptom if it is part of the norm (e.g., caregivers are working with severely cognitively and functionally impaired people and are used to person’s wandering, noisiness, etc.). Focus attention on what has been the individual’s actual behavior over the last 7 days.

D.1 Problem Behavior - Identifies the presence of problem behaviors in the last 7 days (if individual is in a hospital, the last 7 days prior to admission to the hospital) that cause disruption and includes behaviors that are potentially harmful to the person or disruptive in the environment, even though friends, family members, staff appear to have adjusted to the behaviors.

- a. Wandering** moved with no rational purpose, seemingly oblivious to needs or safety
A wandering person may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about the unit in search of food). Wandering may be by walking or by wheelchair.

Note: Do not include pacing as wandering behavior. Pacing back and forth is not considered wandering, and if it occurs, it should be documented as "Repetitive physical movements" under MOOD Section R.1n.

- b. Verbally abusive** others were threatened, screamed at, cursed at
c. Physically abusive others were hit, shoved, scratched, sexually abused
d. Socially inappropriate / disruptive behavior made disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared, threw food/ feces, hoarding, rummaged through others’ belongings
e. Resists care resisted taking medications, injections, ADL assistance or eating. Signs of resistance may be verbal and/or physical (e.g., verbally refusing care, pushing caregiver away, scratching caregiver). This category does **not** include instances where person has made an informed choice not to follow a course of care (e.g., person has exercised his or her right to refuse treatment, and reacts negatively as caregivers try to reinstitute treatment.)

For each disruptive behavior use one of the following codes. Report on the most disruptive behavior across a 24-hour period. **Every box must be coded 0, 1, 2, or 3 for frequency and 0 or 1 for alterability.**

Column A codes: code for the frequency of behavior in the last 7 days.

0. Behavior not exhibited in last 7 days.
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred on 4 to 6 days, but not every day.
3. Behavior of this type occurred daily or more frequently.

Column B codes: alterability of behavioral symptoms

0. Not present or easily altered
1. Behavior not easily altered

D.2A Is professional nursing assessment, observation, and management required at least 3 days per week to manage the above behavior problems? Code "0" if no, code "1" if yes.

If D.2A = "yes," proceed to D.3. Do NOT complete the Supplemental Screen for Behavior.

If D.2A = "no," **and person meets the behavioral impairment threshold** as defined below, then go to Page 2A and complete Section D.2B Behavior.

A "threshold" score for problem behavior is equal to a score of "2" or "3" (occurs at least 4 times per week) in one of these four criteria: wandering, verbally abusive, physically abusive, socially inappropriate/disruptive behavior (1a-1d), per Chapter II, Section 67 of the Maine Medical Assistance Manual.

If the behavioral impairment threshold is met and the person does not need nursing assessment at least 3 days a week then the Supplemental Screen for Behavior must be completed.

D.3 Is professional nursing assessment, observation and management required less frequently than 3 days per week but at least once per month? Code "0" if no, code "1" if yes.

SUPPLEMENTAL SCREENING TOOL Section D.2.B BEHAVIOR.

Section D.2B. BEHAVIOR. Complete this behavioral screen only if the response to D. 2A. is 0 "no" and the person meets the behavioral impairment threshold. A "threshold" score for problem behavior on the eligibility assessment form is equal to a score of "2" or "3" in one of these four criteria (1a-1d) and occurs at least 4 times per week.

Section D.2B. BEHAVIOR. Enter the code that most accurately describes the person's behavior for the last 7 days.

- 1. Sleep patterns:** Enter the number that best describes person's sleep patterns within the last 7 days: 0, 1, 3, or 4.
- 2. Wandering:** Enter the number that best describes person's wandering behavior within the last 7 days: 0, 1, 2, 3, or 4.
- 3. Behavioral Demands on Others:** Enter the number that best describes affect of person's behavior on their living arrangement within the last 7 days: 0, 1, 3, or 4.
- 4. Danger to Self and Others:** Enter the number that best describes the extent to which the individual has been dangerous to self or others within the last 7 days: 0, 1, 2, 3, or 5.
- 5. Awareness of Needs/Judgment:** Enter the number that best describes person's awareness of their needs and level of cooperation in meeting those needs within the last 7 days: 0, 1, 2, or 3.

D.2B. Total Behavior Score: Add the answers to questions 1-5 and enter this number in the box provided. **Return to Section D3 on page 2.**

SECTION E. PHYSICAL FUNCTIONING/STRUCTURAL PROBLEMS

Many consumers are at risk of physical decline. Many elderly consumers have multiple chronic illnesses and are subject to a variety of other factors that can severely impact self-sufficiency. For example, cognitive deficits can limit ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency, particularly for consumers with chronic mental illness or others who may be taking psychotropic medications.

Due to these many, possibly adverse influences, a consumer's potential for maximum functionality is often greatly underestimated by family, staff, and the consumer himself or herself. Thus, all consumers are candidates for rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs. Individualized care plans can be successfully developed only when the consumer's self-performance has been accurately assessed and the amount and type of support being provided to the consumer by others has been evaluated.

Activities of Daily Living (ADL) Self Performance- describes the person's self-care performance in activities of daily living (i.e., what the person actually did alone, without assistance, and/or how much help was provided, not what he or she might be capable of doing). A consumer's ADL self-performance may vary from day to day and within the day (e.g., from morning to night). There are many possible reasons for these variations, including mood, stamina, relationship issues (e.g., willing to perform for a caregiver he or she likes), and medications. The responsibility of the assessor, therefore, is to capture the total picture of the consumer's ADL self-performance over the 7-day period, 24 hours a day, not only how the consumer is at one point in time during 1 day.

In order to accomplish this, it is necessary to gather information from multiple sources (i.e., interviews/discussion with the consumer, and formal and informal caregivers). Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Toileting with a caregiver, be sure to inquire specifically how the consumer moves onto and off of the toilet, how the consumer cleans him/herself, and how the consumer arranges his/her clothing after using the toilet. A consumer can be independent in one aspect of Toileting yet require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The responses in the ADL items are used to record the person's **actual** level of involvement in self-care and the type and amount of support actually received during the last 7 days or **24-48 hours if in a hospital**. In **Column 1, Self-Performance**, enter the code that best describes the person's self-performance for bed mobility, transfer, locomotion, dressing, eating, toilet use, personal hygiene, not including set-up*, and walking, over a 24-hour period during the last 7 days (or 24-48 hour period if the person is in a hospital). ***Exclude "Set-up" Help:** Consider the type of assistance known as "set-up help" (e.g., comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the aide). In evaluating the consumer's ADL Self-Performance, include set-up help within the context of the "0" (Independent) code. For example: If a consumer grooms independently once grooming items are set up for him, code "0" (Independent) for self-performance in Personal Hygiene. For each ADL category, code the appropriate response for the consumer's actual performance during the past seven days. Enter the code in the box following the ADL and its definition, under column A

Self-Performance. Consider the consumer's performance during a 24-hour period, as functionality may vary.

View each activity separately: do not blend activities together.

"Weight-bearing" pertains to the caregiver.

Self-performance codes are:

0. **Independent**- no help or oversight or help/oversight provided only 1 or 2 times during last 7 days or **24-48 hours if in a hospital.**
1. **Supervision**- oversight, encouragement or cueing provided 3+ times OR supervision (3+ times) plus nonweight-bearing physical assistance provided only 1 or 2 times during last 7 days or **24-48 hours if in a hospital.**
2. **Limited Assistance**- person highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3+ times OR limited assistance (3+ times) **plus** weight-bearing support 1 or 2 times during last 7 days or **24-48 hours if in a hospital.**
3. **Extensive Assistance**- while person performed part of activity, help of the following type(s) provided 3 or more times during last 7 days or **24-48 hours if in a hospital.:**
 - Weight-bearing provided 3+ times (caregiver has to bear the weight to accomplish the task)
 - Full caregiver/staff performance during part (but not all) of period
4. **Total dependence**- full caregiver/staff performance of activity during entire period. Complete non-participation by person in all aspects of the ADL. For example, for Self Performance, **e. eating**, to be coded "4", the person must be incapable of taking any food by him/herself. Do not code "4" if the individual can take finger foods or drink from a cup.
5. **Cueing**- spoken instruction or physical guidance, which serves as a signal to do an activity, is required **7 days a week.** Cueing is typically used when caring for individuals who are moderately to severely cognitively impaired.
8. **Activity did not occur at all** during entire period. The person or the caregiver/staff did not perform it.

Code "8" is limited to situations where the ADL activity was not performed and is primarily applicable to full bed-bound persons who were neither transferred nor moved between locations. When an "8" code is entered for self-performance, also enter an "8" code for support. **[Note: The self-performance definitions are mutually exclusive. They do not overlap. Moving from one level of self-performance to the next step requires a change in the number of times that help is provided. To move a person's scoring from Independent to Supervision, for example, oversight or help must increase from 1 or 2 times up to 3 or more times. To move from Supervision to Limited Assistance, non-weight bearing supervision or physical assistance must increase from 1 or 2 times up to 3 or more times.]**

Activities of Daily Living (ADL) Support Provided- determines the intensity of ADL support, focusing on the time or episode when the highest level of support was provided during the last 7 days or, if in a hospital, 24-48 hours.

For each ADL category, code the highest amount of support given in **Column 2, Support**, irrespective of the frequency over the specific period of time. Code regardless of the person's self-performance classification (e.g., if someone was independent but received a 1-person physical assist one or two times during the period). Code at the level of assistance needed to do the activity.

Support codes are:

0. **No setup or physical help**
1. **Setup help only**- person is provided with materials or devices necessary to perform the activity of daily living independently. Examples of 'setup help only' include:
 - locomotion**- handing person a walker or locking wheels on wheelchair;
 - dressings**- retrieving clothes from closet and laying out on person's bed;
 - eating**- cutting meat and opening containers at meals;
 - personal hygiene**- providing wash basin or grooming articles;
 - bathing**- placing bathing articles at tubside within person's reach.
2. **One-person physical assist**
3. **Two + persons physical assist**
5. **Cueing**- Cueing support is required 7 days per week
8. **Activity did not occur** during the entire period- when an "8" code is entered for support, also enter an "8" code for self-performance.

These codes are mutually exclusive. They do not overlap. Moving from one level of support to the next requires a change in the amount of assistance provided.

[Note: Self-Performance for Bathing- Bathing is coded independently of the other ADLs because it is usually done less frequently; bathing is not a daily activity for many people. The frequencies used to define the other ADLs are not appropriate for an activity that might occur only once a week.]

In **Column 1, Self-Performance**, enter the **special bathing self-performance code** that best describes the person's most dependent level of self-performance. When coding, apply the bathing self-performance code that reflects the highest amount of assistance that the person received during any bathing episode. Enter "8" if bathing did not occur. Bathing self-performance codes are:

0. **Independent**- No help provided
1. **Supervision**- oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
5. **CUEING**-Cueing support required 7 days a week
8. Activity did not occur during entire 7 days.

In **Column 2, Support**, enter the ADL support codes defined in **Section E.2**.

Note: See APPENDIX F for examples of scoring ADLs.

CLINICAL DETAIL (p. 3 of 5) MEDICATIONS & DIAGNOSIS

Header includes the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #, and Assessment Date.** THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE.**

SECTION F. MEDICATIONS LIST

List all medications given during the last 7 days. Include medications used regularly less than weekly as part of the person's treatment regimen.

For consumers being assessed for 'Venipuncture Only' services under PDN, any medications which need to be monitored through venipuncture should appear on this list.

For consumers being assessed for Psychiatric Medication Services under PDN, all medications being administered or monitored should appear on this list, as well as any medications taken within the last 7 days.

- 1.** List the **medication name** and the **dosage**.
- 2. Route of Administration:** list the appropriate code, 1 through 10.
- 3. Frequency:** use the appropriate frequency code as listed.
- 4. PRN-n:** If the frequency code is "PR," record the number of times during the past 7 days that each PRN medication was given. Do not use this column for scheduled medications.
- 5. Drug Code:** Enter the National Drug Code (NDC). The last 2 digits of the 11-digit define package size and have been omitted from the codes listed in the manual Appendix. If using this Appendix, place the first digit in the first space. The last two spaces will be blank.

SECTION G. MEDICATION

Medication preparation and administration

Intent: To record whether the person prepared and administered any of his/her own medications in the last 7 days.

1 a. Preparation/Administration: Enter the number in the box from the following that describes preparation and administration of medications for person.

Coding:

0. Person prepared and administered **All** of his/her medications
1. Person prepared and administered **Some** of his/her medications.
2. Person prepared **None** of his/her medications
3. Person **had no** medications in the last 7 days
4. Person did not prepare but did self administer all medications
5. Facility prepares and administers medications
6. Person requires administration of medications due to severe and disabling mental illness.

1 b. Medication Compliance

Intent: To determine if there are specific or potential problems with the person's medications or the way the person takes medications.

Process: Review the person's medication, question the consumer, family or formal and informal caregivers to assess how well the person complies with the medication ordered by a physician/psychiatrist. If in a facility, check with direct care staff.

Coding: Enter the number in the box from the following that represents the person's level of compliance during the last 30 days.

0. Person always compliant
1. Person compliant some of the time (80% of time or more often) or compliant with some medications
2. Person rarely or never compliant
3. Person had no medications in the last 7 days.
4. Person requires monitoring of medications due to severe and disabling mental illness.

1 c. Self Administration

Intent: To record whether the person self-administered any of the following medications in the last 7 days: insulin, oxygen, Nebulizers, Nitropatch, glucoscan, over-the counter medications, or other self-administered medications.

Coding: Check all responses a, b, c, d, e, f, g, or h, that apply. Specify the medications if g. Other is checked. If the person did not self-administer any medications in last 7 days, check h. NONE OF ABOVE.

Section H. DIAGNOSES

Check only those diagnoses that relate to the consumer's current ADL status, cognitive status, mood or behavior status, medical treatments, monitoring, or risk of death. In general, these are conditions that drive the current care plan. Do not include conditions that have been resolved or no longer affect the consumer's functioning. Do not list inactive diagnoses.

Endocrine/Metabolic/Nutritional: Check if applicable

- a. Diabetes mellitus 250.00
- b. Hyperthyroidism 242.9 [0 or 1]
- c. Hypothyroidism 244.9

Heart/Circulation: Check if applicable

- d. Arteriosclerotic heart disease (ASHD) 414.00 through 414.03
- e. Cardiac dysrhythmia 427.9
- f. Congestive heart failure 428.0

- g. Deep vein thrombosis 453.8
- h. Hypertension (unspecified) 401.9
- i. Hypotension (unspecified) 458.9
- j. Peripheral vascular disease (unspecified) 443.9
- k. Other cardiovascular disease 429.2

Musculoskeletal: Check if applicable

- l. Arthritis (unspecified site) 716.90
- m. Hip fracture (unspecified site or NOS [not otherwise specified]) 820.9
- n. Missing limb (e.g., amputation) 736.89
- o. Osteoporosis (unspecified) 733.00
- p. Pathological bone fracture (unspecified sites) 733.10

Neurological: Check if applicable

- q. Alzheimer's disease 331.0
- r. Aphasia 784.3
- s. Cerebral palsy (unspecified) 343.90
- t. Cerebrovascular accident (stroke) (NOS acute) 436
- u. Dementia other than Alzheimer's (Senile dementia, NOS) 290.0
- v. Hemiplegia/Hemiparesis 342.90 through 342.92
- w. Multiple sclerosis (NOS) 340
- x. Paraplegia 344.1
- y. Parkinson's disease 332.0
- z. Quadriplegia 344.00 through 344.09
- aa. Seizure disorder 780.3
- bb. Transient ischemic attack (TIA) (unspecified) 435.9
- cc. Traumatic brain injury (unspecified) 854.00

Psychiatric/Mood: Check if applicable.

- dd. Anxiety disorder (unspecified) 300.00
- ee. Depression 311
- ff. Manic depression (bipolar disease) 296.8
- gg. Schizophrenia (unspecified) 295.90

Pulmonary: Check if applicable.

- hh. Asthma (unspecified) 493.90
- ii. Emphysema 492.8/COPD 496

Sensory: Check if applicable.

- jj. Cataracts (unspecified) 366.9
- kk. Diabetic retinopathy 362.01, 362.02 and 250.50 through 250.53
- ll. Glaucoma (unspecified) 365.9
- mm. Macular degeneration (unspecified) 362.50

Other: Check if applicable

nn. Allergies 995.3 (and specify allergies if checked)

oo. Anemia 285.9

pp. Cancer (unspecified as to site or stage) 199.1

qq. Renal failure (unspecified) 586

rr. Tuberculosis-TB

ss. HIV 042

tt. Mental retardation (e.g., Down's Syndrome, Autism, or other organic condition related to Mental Retardation or Developmental disability (MR/DD) (unspecified) 319

uu. Substance abuse (alcohol or drug) 305

vv. Other psychiatric diagnosis (e.g., paranoia, phobias, personality disorder)

ww. Explicit terminal prognosis

Check xx if NONE OF ABOVE.

2. OTHER CURRENT DIAGNOSES AND ICD-9 CODES: Complete if appropriate.

CLINICAL DETAIL (p. 4 of 5)

The Header includes the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #, and Assessment Date.** THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE.**

SECTION I. COMMUNICATION/HEARING PATTERNS

There are many possible causes for the communication problems experienced by people of all ages. Usually a communication problem is caused by more than one factor. For example, a person might have aphasia as well as a long-standing hearing loss; or he or she might have dementia and word finding difficulties and a hearing loss. The person's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or isolating environment can inhibit opportunities for effective communication.

Deficits in the person's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions. Deficits in ability to make oneself understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and gesturing.

Be alert to what you have to do to communicate with the person. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use gestures, or if the person needs to see your face to know what you are saying, or if you have to take the person to a more quiet area to conduct the interview - all of these are indications that there is a hearing problem. If the person is in a nursing facility, ask the activities personnel how the person hears during group activities.

The assessor should interact with the person. Observe and listen to the person's efforts to communicate with you. Observe the person's interactions with others in different settings (e.g., one-on-one, group) if possible. Consult with formal and informal caregivers and family members.

1. Hearing: Enter 0, 1, 2, or 3, corresponding to the appropriate response. If hearing appliance is used, code person's ability to hear with hearing appliance.

- 0. Hears adequately.** The person hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities.
- 1. Minimal difficulty.** The person hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-to-one situations.
- 2. Hears in special situations only.** Although hearing-deficient, the person compensates when the speaker adjusts tonal quality and speaks distinctly, or the person can hear only when the speaker's face is clearly visible.
- 3. Highly impaired - absence of useful hearing.** There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

- 2. Communication Devices/Techniques:** Check all that apply during last 7 days from a, b, c, or d.
- a. Hearing aid, present and used.** A hearing aid or other assistive device is available to the person and is used regularly.
 - b. Hearing aid, present and not used regularly.** The hearing aid is used only occasionally or is broken.
 - c. Other receptive communication techniques used** (e.g., lip reading) A mechanism or process is used by the person to enhance interaction with others, e.g., touching to compensate for hearing deficit, writing is done by another person, use of a communication board.
 - d. None of above**

3. Making Self Understood: Person's ability to communicate requests, needs, whether in speech, writing, sign language, or a combination of these (including use of word or key board). Enter 0, 1, 2, or 3 corresponding to appropriate response.

- 0. Understood.** The person expresses ideas clearly, without difficulty.
- 1. Usually understood.** The person has difficulty finding the right words or finishing thoughts, resulting in delayed responses; or the person requires some prompting to make self understood.
- 2. Sometimes understood.** The person has limited ability, but is able to express concrete requests regarding at least basic needs, e.g., food, drink, sleep, toilet, pain.
- 3. Rarely/ never understood.** At best, understanding is limited to others' interpretation of highly individual, person-specific sounds or body language/ gestures.

4. Ability to Understand Others: Check 0, 1, 2, or 3.

- 0. Understands.** The person clearly understands the speaker's message(s) and demonstrates comprehension by words or actions/ behaviors.
- 1. Usually understands.** The person may miss some part or intent of the message but comprehends most of it.
- 2. Sometimes understands.** The person demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or directions.
- 3. Rarely/ never understands.** The person demonstrates very limited ability to understand communication. If the person is in a nursing facility, the staff has difficulty determining whether the person comprehends messages, based on verbal and nonverbal responses. Or, the person can hear sounds but does not understand messages.

SECTION J. VISION PATTERNS

1. Vision: Check 0, 1, 2, 3, or 4.

- 0. Adequate.** Sees fine detail, including regular print in newspapers/ books.
 - 1. Impaired.** Sees large print, but not regular print in newspapers, books.
 - 2. Moderately impaired.** Limited vision; not able to see newspaper headlines, but can identify objects.
 - 3. Highly impaired.** Object identification is in question, but eyes appear to follow objects.
- Note: many people with severe cognitive impairment are unable to participate in vision

screening because they are unable to follow directions or are unable to tell you what they see. However, many such people appear to “track” or follow moving objects in their environment with their eyes. For people who do this, check “3.”

4. Severely impaired. No vision or sees only light, colors, or shapes, eyes do not appear to follow objects

2. Visual Appliances: Check “0” if no, “1” if yes.

- a. Glasses, contact lenses
- b. Artificial eye.

SECTION K. NUTRITIONAL STATUS

This section (K.1, 2, and 3) is optional if the information is not available, based on location.

1. Weight: record weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard practice (e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes)

2. Weight change: Code appropriate response for weight change in last 180 days.

0. No weight change
1. Unintended weight loss - 5% or more in last 30 days or 10% or more in last 180 days.
2. Unintended weight gain - 5% or more in last 30 days or 10% or more in last 180 days.

3. Nutritional problems or approaches: Check all items that are applicable.

- a. Chewing or swallowing problem** Inability to chew food easily and without pain or difficulties, regardless of cause e.g., person uses ill-fitting dentures, or has neurologically impaired chewing mechanism, joint pain, or a painful tooth.
- b. Complains about the taste of many foods** The sense of taste can change as a result of health conditions or medications. Also, complaints can be culturally based, e.g., a person used to eating spicy foods may find meals at a facility bland.
- c. Regular or repetitive complaints of hunger** On most days (at least 2 out of 3) person asks for more food or complains of feeling hungry (even after eating a meal)
- d. Leaves 25% or more of food uneaten at most meals** Eats less than 75% of food (even when substitutes are offered) at least 2 out of 3 meals a day
- e. Therapeutic diet** A diet ordered to manage problematic health conditions. Examples include calorie-specific, low-salt, low-fat, lactose, no added sugar, and supplements during meals.
- f. Mechanically altered (or pureed) diet** A diet specifically prepared to alter the consistency of foods in order to facilitate oral intake. Diets for people who can only take liquids that have been thickened to prevent choking are included in this definition.
- g. Noncompliance with diet** Person does not comply with specific diet orders.
- h. Food allergies** Specify any known food allergies that the person has.
- i. Restrictions** Specify any dietary restrictions, such as caffeine, chocolate, or meat that the person may have.
- j. NONE OF ABOVE**

SECTION L. CONTINENCE

If the person is in a nursing home, review the record. If the person is at home, question the family or formal and informal caregivers. Be sure to validate both the accuracy of reported and written information with the person. Make sure that your discussions are held in private. Control of bladder and bowel function is a sensitive subject, particularly for people who are struggling to maintain control. Many people with poor control will try to hide their problems out of embarrassment or fear of retribution. Validate continence patterns with people who know the individual well. Remember to consider continence patterns over the last **14 day period, 24 hours** a day, including weekends.

A five-point coding pattern is used to describe incontinence patterns. Notice that in each category, different frequencies of incontinent episodes are specified for bladder and bowel. The reason for these differences is that there are more episodes of urination per day and week, compared to bowel movements, which typically occur less often.

1. Bladder Continence: Check 0, 1, 2, 3, or 4 for the last 14 days.

- 0. Continent** complete control.
- 1. Usually continent** incontinent episodes once a week or less
- 2. Occasionally incontinent** 2 or more times a week but not daily
- 3. Frequently incontinent** tended to be incontinent daily, but some control present
- 4. Incontinent** Bladder incontinent all (or almost all) of the time

2. Bowel Continence: Check 0, 1, 2, 3, or 4 for the last 14 days.

- 0. Continent** complete control.
- 1. Usually continent** bowel incontinent episodes less than weekly.
- 2. Occasionally incontinent** bowel incontinent episode once a week.
- 3. Frequently incontinent** bowel incontinent episodes 2-3 times a week.
- 4. Incontinent** Bowel incontinent all (or almost all) of the time

3. Appliances/Programs: Be sure to ask about any items that are usually hidden from view because they are worn under street clothing. Check all that apply or check f. NONE OF ABOVE.

- a. External (condom) catheter** A urinary collection appliance worn over the penis
- b. Indwelling catheter** A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.
- c. Pads, briefs used** Any type of absorbent, disposable or reusable undergarment or item, whether worn by the person (e.g., diaper, adult brief) or placed on the bed or chair for protection from incontinence. Does NOT include the routine use of pads on beds where person is never or rarely incontinent.
- d. Ostomy present** Any type of ostomy of the gastrointestinal or genitourinary tract.
- e. Scheduled toileting/ other program** Timed/ scheduled toileting of the person or any other program such as bladder retraining
- f. NONE OF ABOVE**

SECTION M. BALANCE

1. Accidents: Check all items that apply, items a. through d, or e. NONE OF ABOVE. Are there any environmental changes or adaptive equipment needs that may assist in prevention of falls? Include observations and description of fall in assessor notes. Code environmental observations in Section Q.2, Environmental Assessment, if applicable.

- a. Fell in past 30 days
- b. Fell in past 31-180 days
- c. Hip fracture in last 180 days
- d. Other fracture in last 180 days
- e. NONE OF ABOVE

2. Danger of Fall: Check all items that apply, items a through c, or d. NONE OF ABOVE. Should a Physical Therapy Evaluation be considered, with review of any safety issues in the environment? Is there a need for home modification?

- a. Has unsteady gait.
- b. Has balance problems when standing.
- c. Limits activities because person or family fearful of person falling.
- d. NONE OF ABOVE

SECTION N. ORAL/DENTAL STATUS

1. Oral Status and Disease Prevention: Check all that apply, items a through d, or e. NONE OF ABOVE.

- a. Has dentures or removable bridge
- b. Some/all natural teeth lost- does not have or does not use dentures (or partial plates)
- c. Broken, loose, or carious teeth
- d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses or rashes
- e. NONE OF ABOVE

SECTION O. SKIN CONDITIONS

1. Skin problems: Document presence of skin problems and conditions (other than ulcers) that are risk factors for more serious problems. Check all that apply in the last 180 days. If f. Other, specify. If none, check g. NONE OF ABOVE.

- a. Abrasions** (scrapes) includes skin that has been scraped or rubbed away such as skin tears.
- b. Burns** (second or third degree) Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first-degree burns (changes in skin color only.)
- c. Bruises** Includes ecchymoses, localized areas of swelling, tenderness and discoloration.
- d. Rashes, itchiness, body lice, scabies** Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat and bacteria, viruses, contact with irritating

substances such as urine or detergents, allergies, etc.), including rashes (dermatitis) within skin folds (Intertrigo).

e. Open sores or lesions A wound, injury, or destructive change in body tissue (e.g., a sore or boil); includes a stasis ulcer, eczema or psoriasis.

f. NONE OF ABOVE

2. Pressure ulcers: Check for the presence of an ulcer any where on the body. This would include an area of persistent skin redness (without a break in the skin) that does not disappear when pressure is relieved (Stage 1); partial thickness loss of skin layers that presents as an abrasion, blister, or shallow crater (Stage 2); full thickness of skin lost, exposing subcutaneous tissues. Presents as deep craters in the skin (Stage 3); and full thickness of skin and subcutaneous tissue lost, exposing muscle or bone (Stage 4.) Check “0” no, or “1” yes.

3. Foot Problems: Check “0” no or “1” yes for questions a. and b.

a. Person or someone else inspects person’s feet on a regular basis

b. One or more foot problems or infections such as corns, calluses, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, onychomycosis.

CLINICAL DETAIL (p.5 of 5)

Header Complete the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #, and Assessment Date.**

SECTION P. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Instrumental Activities of Daily Living (IADLs) Self Performance- describes the person's self-care performance in instrumental activities of daily living (i.e., what the person actually did alone, without assistance, and/or how much help was provided during the last 7 days for daily IADLs (1.a-1d) and during the last 14 days for other IADLs (2.a-2.d), not what he or she might be capable of doing). A consumer's IADL self-performance may vary from day to day and within the day (e.g., from morning to night). There are many possible reasons for these variations, including mood, stamina, relationship issues. The responsibility of the assessor, therefore, is to capture the total picture of the consumer's IADL self-performance over the 7-day and 14-day periods, 24 hours a day, not only how the consumer is at one point in time during 1 day.

In order to accomplish this, it is necessary to gather information from multiple sources when possible (i.e., interviews/discussion with the consumer, formal and informal caregivers). Ask questions pertaining to all aspects of the IADL activity definitions. Be sure to question how activity is accomplished when help is not available.

In **Column 1, Self-Performance**, enter the code that best describes the person's self-performance. For each IADL category, code the appropriate response for the consumer's actual performance. Enter the code in the box following the IADL and its definition, under column 1 Self-Performance.

IADL SELF-PERFORMANCE CODES:

- 0. INDEPENDENT:** (with/without assistive devices)-No help provided.
- 1. INDEPENDENT WITH DIFFICULTY:** Person performed task, but did so with difficulty or took a great amount of time to do so.
- 2. ASSISTANCE/DONE WITH HELP:** Person involved with activity but help (including supervision, reminders, and /or physical "hands-on" help) was provided.
- 3. DEPENDENT/DONE BY OTHERS:** Full performance of the activity was done by others. The person was not involved at all each time the activity was performed.
- 8. ACTIVITY DID NOT OCCUR:** The IADL activity was not performed. It did not occur at all during the time period.

IADL SUPPORT CODES:

- 0. NO SUPPORT PROVIDED:** No help or oversight was provided during the time period.
- 1. SUPERVISION/CUEING PROVIDED:** Oversight, encouragement, cueing or supervision was provided. No hands-on physical assistance provided
- 2. SET-UP HELP ONLY:** Consumer involved in activity, but requires assistance with set-up such as reading or obtaining phone numbers, bus schedules, and other materials. No hands-on physical assistance provided.
- 3. PHYSICAL ASSISTANCE WAS PROVIDED:** Consumer involved some or all of the time but received physical/hands-on help from others with part of the activity when the IADL was performed.
- 4. TOTAL DEPENDENCE:** Full performance of the activity done by others. The person was not involved at all when the activity was performed.
- 8. ACTIVITY DID NOT OCCUR:** The IADL activity was not performed. It did not occur at all during the time period.

Total Dependence in IADLs where Self-performance = 3, Support = 4

Total Dependence scores in IADLs indicate that someone other than the consumer is performing the task for the consumer. The following are examples where total dependence scores are valid:

Light Meals: Person is unable to pour glass of milk, cup of tea without assistance.

Main Meals: Person was unable to prepare any main meals in last 7 days. Receiving Meals on Wheels does not indicate total dependence.

Telephone: Person does not use the phone at all. Phone calls occur and are handled completely by others. Person does not use the phone for communication at all.

Light Housekeeping: Person is not involved at all in any light housekeeping tasks.

Managing Finances: Person does not handle their own finances. Someone else manages finances.

Routine Housework: Person's routine housework is performed by someone else.

1. DAILY INSTRUMENTAL ACTIVITIES Code each of the following for level of independence based on person's involvement in the activity *in the last 7 days*.

1a. Meal preparation How the person prepares light meals or snacks. This includes obtaining food and utensils within the home, opening packages, and other necessary preparation such as pouring, mixing or warming; does not include grocery shopping or main meal preparation.

1b. Main meal preparation: How the person prepares the main meal. This includes planning the menu, obtaining the food and other necessary activities required to prepare the main meal of the day. Check the box for Meals on Wheels if appropriate and indicate number of times per week the meals are provided

1c. Telephone: How the person uses the phone. This includes locating phone numbers, dialing the correct number, and communicating by phone.

1d. Light housework: How the person does household tasks. This includes washing/drying dishes, dusting, making their bed, or taking care of their belongings, in the home.

2. OTHER INSTRUMENTAL ACTIVITIES OF DAILY LIVING Code each of the following for level of independence based on person's involvement in the activity *in the last 14 days*.

2a. Managing Finances: How the person handles finances. The way the person performs bank transactions (cashing or depositing checks), writes checks and manages checkbook, pays bills; does not include handling cash.

2b. Routine housework: How the person did the routine housework such as vacuuming, cleaning floors, trash removal, cleaning bathrooms, as needed

2c. Grocery shopping: How the person actually purchases groceries and other incidentals. This includes selecting items at the store. It does not include arranging transportation for shopping.

2d. Laundry: How person does laundry. Includes sorting, washing, or folding laundry either in or outside the home; does not include transportation.

3. TRANSPORTATION

Check all that apply from items a, b, or c, or d for level of independence based on person's involvement in the activity *in the last 30 days, or check e. if activity did not occur*.

4. PRIMARY MEANS OF LOCOMOTION

Code for the primary mode of locomotion for (a) indoors and (b) outdoors or code 5, Activity does not occur.

SECTION Q. ENVIRONMENTAL ASSESSMENT

1. If a person resides in a facility such as a nursing facility, RCF, or hospital, assessor may check the box provided and proceed to Section R.

2. Home environment: If person is temporarily in an institution, base assessment on home visit. Check any of the following items a. Lighting, b. Flooring and carpeting, c. Bathroom and toilet room environment, d. Kitchen environment, e. Heating and cooling, f. Personal safety, and/or g. Access to home, that make home environment hazardous or uninhabitable. Or check h., NONE OF ABOVE. Be sure to include in assessor notes need for follow-up by HCCA when applicable.

2. Trade-Offs: Because of limited funds, during the last month, person made trade-offs among purchasing any of the listed items. Check any of the following items a. home heat, b. adequate food, c. necessary physician care, d. prescribed medications, e. home care. Or check f., NONE OF ABOVE.

SECTION R. MOOD

Mood distress is a serious condition and is associated with declines in health and functional status. Associated factors include poor adjustment to living environment or new location, functional impairment, resistance to daily care, inability to participate in or withdrawal from activities, isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain.

In many facilities, staff has not received specific training in how to evaluate people who have distressed mood or behavioral symptoms. In home, formal and informal caregivers and family may not have received specific training in how to recognize changes in a person's mood or behaviors. Therefore, many problems are not recognized, diagnosed and may go untreated.

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

Feelings of psychic distress may be expressed directly by the person who is depressed, anxious, or sad. However, statements such as "I'm so depressed" are rare in the older population. Rather, distress is more commonly expressed through verbal expressions of distress.

Distress may also be expressed non-verbally through sleep cycle issues and by sad, apathetic, anxious appearance. The person may withdraw from activities and become less talkative and more isolated. Be assured that asking a person about sad or anxious mood, feeling depressed or even feeling suicidal will not "create" those feelings, although it may allow the person to voice those feelings to you for the first time.

Code for behavior in the last 30 days irrespective of the assumed cause. Select from the following choices.

- 0. Indicator not exhibited in last 30 days.**
- 1. Indicator of this type exhibited up to 5 days a week.**
- 2. Indicator of this type exhibited daily or almost daily (6 or 7 days per week).**

VERBAL EXPRESSIONS OF DISTRESS

- a. Person made negative statements** e.g., nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die.
- b. Repetitive questions** e.g., "Where do I go; What do I do?"
- c. Repeated verbalizations** e.g., Calling out for help, "God help me."
- d. Persistent anger with self or others** e.g., easily annoyed, anger at placement in domiciliary home; persistent anger at care received
- e. Self-deprecation** e.g., "I was nothing," "I am of no use to anyone."
- f. Expressions of what appear to be unrealistic fears** e.g., fear of being abandoned, left alone, being with others
- g. Recurrent statements that something terrible is about to happen.** e.g., believes he or she is about to die, have a heart attack
- h. Repetitive health complaints** e.g., persistently seeks medical attention, obsessive concern with bodily functions
- i. Repetitive anxious complaints** e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues.

SLEEP-CYCLE ISSUES

- j. Unpleasant mood in morning**
- k. Insomnia / change in usual sleep pattern** e.g., difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep

LOSS OF INTEREST

- l. Sad, pained, worried facial expressions** e.g., furrowed brow
- m. Crying, tearfulness**
- n. Repetitive physical movements** e.g., pacing, hand-wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

- o. Withdrawal from activities of interest** e.g., no interest in long-standing activities or being with family, friends
- p. Reduced social interaction** e.g., less talkative, more isolated

2. MOOD PERSISTENCE

The assessor will determine whether one or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the person over the last seven days. In order to determine mood persistence, it is necessary to observe the person, discuss the situation with formal and informal caregivers, **and** review the record.

One or more indicators of depressed, sad, or anxious mood were not easily altered by attempts to "cheer up," console or reassure the person in the last 7 days. *Code for behavior in the last 7 days.* Select from the following choices.

0. No mood indicators
1. Indicators present, easily altered.
2. Indicators present, not easily altered.

3. MOOD

Record person's status or abilities now as compared to 180 days ago. Talk with consumer and family members. Ask if they have noticed an improvement or worsening of mood indicators. Ask them to compare current status to status of 6 months ago. If the person is a new admission or has not been in a facility for 180 days, review the record and make an assessment based on that information.

Person's current mood status compared to person's status 180 days ago. Select from the following choices.

0. No change
1. Improved
2. Declined

ELIGIBILITY DETERMINATION

(p. 1 of 6)

Eligibility determination is calculated by completing the scoring pages that collect the outcome of individual sections of the eligibility form.

Eligibility Determination Header includes the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #, and Assessment Date.**

CONGREGATE HOUSING

- CH.1 In Clinical Detail, Section E, Physical Functioning/Structural Problems, are at least 2 ADLs from the following: bed mobility, transfer, locomotion, toilet use, bathing, dressing or eating, coded with a 2, 3, or 4 in self-performance and a 2 or 3 in support? Check 'Yes' or 'No'.
- CH.2 In Clinical Detail, Section P, Instrumental Activities of Daily Living, are at least 3 IADLs from the following: 1.b main meal preparation, 2.b routine housework, 2.c grocery shopping, 2.d laundry, coded with a 2 or 3 in self-performance and a 3 or 4 in support? Check 'Yes' or 'No'.
- CH.3 In Clinical Detail, Section E, Physical Functioning/Structural Problems, is at least 1 ADL from the following: bed mobility, transfer, locomotion, toilet use, bathing, dressing or eating, coded with a 2, 3, or 4 in self-performance and a 2 or 3 in support **AND** at least 2 IADLs from the following: 1.b main meal preparation, 2.b routine housework, 2.c grocery shopping, 2.d laundry, coded with a 2 or 3 in self-performance and a 3 or 4 in support? Check 'Yes' or 'No'.

If the answer to CH.1, CH.2 **or** CH.3 is Yes, then consumer appears to be functionally eligible for Congregate Housing.

ADULT DAY PROGRAM

- AD.1 In **Clinical Detail, Section E, Physical Functioning/Structural Problems**, were **d, e, f** and **4** (dressing, eating, toilet use, and bathing) all coded with a "5" (cueing) in **Self-performance AND Support**? Check 'Yes' or 'No'.
- AD.2 In **Clinical Detail, Section E, Physical Functioning/Structural Problems**, was 1 or more of the following 7 ADLs (bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in **Self-performance AND** a 2 or 3 in **Support**?

If the answer to either AD.1 or **AD.2** is Yes, score this section with a 1. The consumer appears to be functionally eligible for the **Adult Day Program**.

HOMEMAKER SERVICES

HM.1 In **Clinical Detail, Section P, Instrumental Activities of Daily Living**, are at least 3 of the following IADLs: 1b. main meal preparation, 2b. routine housework, 2c. grocery shopping, or 2d. laundry, coded with a 2 or 3 in **Self-performance** AND a 3 or 4 in **Support**? Check ‘Yes’ or ‘No’.

HM.2 In **Clinical Detail, Section E, Physical Functioning/Structural Problems**, are g. personal hygiene or d. dressing, coded with a 2, 3, or 4 in **Self-performance** AND a 2 or 3 in **Support** AND are at least 2 of the following: 1b. main meal preparation, 2b. routine housework, 2c. grocery shopping, or 2d. laundry coded with a 2 or 3 (needs assistance or dependent) in **Self-performance** AND a 3 or 4 in **Support**? Check ‘Yes’ or ‘No’.

If the answer to either **HM.1** or **HM.2** is Yes, score this section with a 1. Consumer appears to be functionally eligible for **BEAS Homemaker Services**.

MEDICAID DAY HEALTH SERVICES

D.1. In **Clinical Detail, Section E, Physical Functioning/Structural Problems**, were **d, e, f** and **4** (dressing, eating, toilet use, and bathing) all coded with a “5” (cueing) in **Self-performance** AND **Support**? Check ‘Yes’ or ‘No’.

D.2 In **Clinical Detail, Section E., Physical Functioning/Structural Problems**, were 2 or more of the following 7 ADLs (bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in **Self-performance** AND a 2 or 3 in **Support**? Check ‘Yes’ or ‘No’.

If the answer to either **D.1** or **D.2** is “yes,” score this section with a “1.” Person appears to be medically eligible for **Medicaid Day Health Services**.

HOME BASED CARE

ELIGIBILITY DETERMINATION (p.2 of 6)

Header includes the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #, and Assessment Date.** THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE.**

- Level 1** - Must need at least limited assistance and one person physical assist with 1 ADL and the sum of the 7 ADLs, HBC Nursing Needs (Section A items 1-11 coded with a 1, 2, 3, or 4), and IADL needs (grocery, laundry, main meal preparation, housework) is equal to or greater than 3.
- Level 2** – Matches current At-Risk PDN Eligibility. Must have a PDN Nursing need (Section A, Section B, Cognition, Behavior items) at least once a month and 2 of the 7 ADLs scored with at least limited assistance and one person physical assist.
- Level 3** - New Level for consumers without nursing need who have increased ADL needs but are not yet NF level of care. Needs at least limited assistance and one-person physical assist with 2 Shaded ADLs AND assistance/done with help plus physical assistance with at least 3 of the 4 IADLs (grocery, laundry, main meal preparation, housework)
- Level 4** – Must meet current NF Eligibility as defined in Section 67.02-3 of the Maine Medical Assistance Manual.
-

LEVEL 1

- H.1.A** In **Clinical Detail, Section E, Physical Functioning/Structural Problems**, were **d, e, f** and **4** (dressing, eating, toilet use, and bathing) all coded with a “5” (cueing) in **Self-Performance AND Support**? Check ‘Yes’ or ‘No’.
- H.1.B** In **Clinical Detail, Section E, Physical Functioning/Structural Problems**, how many ADLs from the following 7 ADLs (bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing) were coded with a 2, 3, or 4 in **Self-performance** AND a 2 or 3 in **Support**? Place the total number in the box.
- H.1.C** In **Clinical Detail, Section A, Professional Nursing Services, items 1-11**, how many boxes were coded with at least a “1” (needed nursing service at least one day a week)? Place the total number in the box.
- H.1.D** In **Clinical Detail, Section P, Instrumental Activities of Daily Living**, how many IADLs from the following: 1b. main meal preparation, 2b. routine housework, 2c. grocery shopping, or 2d. laundry were coded with a “2” or “3” (assistance/done with help or dependent/done by others) in self-performance and a “3” or “4” in support? Place the total number in the box.

Add the numbers in the 3 boxes **H.1.B, H.1.C, and H.1.D** and put the sum in the “**Total**” **Box**.

H.1.E If the answer to **H.1.A** (cueing) is “yes,” score this section with a “1.”

H.1.F IF the person requires assistance with at least 1 ADL from the following 7 ADLs: bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing (Section E, items a, b, c, d, e, f, or 4), **AND** the **TOTAL** sum from **H.1.B, H.1.C, and H.1.D** is 3 or more, score this section with a “1.”

If **H.1.E** or **H.1.F** are scored with a “1,” the person appears to be functionally eligible for **Home Based Care – Level 1**.

LEVEL 2

H.2 If person is medically eligible for “At-Risk” Private Duty Nursing (R.9 on page 5 of 6 under Eligibility Determination), score this section with a “1”.

If **H.2** is scored with a “1,” the person appears to be functionally eligible for **Home Based Care – Level 2**.

LEVEL 3

H.3.A In Section E, Physical Functioning/Structural Problems, are at least 2 ADLs from the following: bed mobility, transfer, locomotion, eating, or toilet use coded with a 2, 3, or 4 in self-performance and a 2 or 3 in support **AND** in Section P, Instrumental Activities of Daily Living, are at least 3 IADLs from the following: 1.b main meal preparation, 2.b routine housework, 2.c grocery shopping, 2.d laundry, coded with a 2 or 3 in self-performance and a 3 or 4 in support?

H.3 If the answer to 3.A is Yes, score this section with a “1”.

If **H.3** is scored with a “1,” the person appears to be functionally eligible for **Home Based Care – Level 3**.

LEVEL 4

H.4 If person is medically eligible for NF Level of Care (NF.7 on page 6 of 6 under Eligibility Determination), score this section with a “1”.

If **H.4** is scored with a “1,” the person appears to be functionally eligible for **Home Based Care – Level 4**.

COGNITIVE CAPACITY (p.3 of 6)

CONSUMER DIRECTED PROGRAMS- Sections 12, 22 under MMAM, Section 73 under BEAS Policy Manual

VOUCHER OPTION- Section 63.05 under BEAS Policy Manual.

In **Section A, Identification and Background Information**, is A.17.a, Legal Guardian, checked? Check 'Yes' or 'No'.

If 'Yes', consumer does have a legal guardian, do not continue scoring for consumer-directed programs. Consumer who has a legal guardian is not eligible for consumer-directed programs.

If 'No', consumer does not have a legal guardian, continue scoring for consumer-directed programs.

ABILITY TO SELF-DIRECT INDICATORS

1. In Clinical Detail, Section C.3, is Cognitive Skills for Daily Decision-Making coded with a 0 or 1 (independent or modified independence)? Check 'Yes' or 'No'
2. In Clinical Detail, Section I, Communication/Hearing Patterns, is I.3, Making Self Understood coded with a 0, 1, or 2? Check 'Yes' or 'No'
3. In Clinical Detail, Section I, Communication/Hearing Patterns, is I.4, Ability to Understand Others coded with a 0, 1, or 2? Check 'Yes' or 'No'
4. In Clinical Detail, Section P, Instrumental Activities of daily Living, is P.2.a, Managing Finances coded with a 0, 1, or 2 in Self Performance (cannot be = 3 or 8)? Check 'Yes' or 'No'
5. In Clinical Detail, Section P, Instrumental Activities of daily Living, is P.2.a, Managing Finances coded with a 0, 1, 2, or 3 in Support (cannot be = 4 or 8)? Check 'Yes' or 'No'

CC.1 If all the answers to the indicator questions above are "Yes", enter a "1" in box. Person appears to have cognitive capacity to self-direct their care in the consumer-directed programs or manage the voucher option.

CONSUMER-DIRECTED PCA SERVICES

P.1 In **Clinical Detail, Section E., Physical Functioning/Structural Problems**, are at least 2 ADLs from the following 7 ADLs (bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing) coded with a 2, 3, or 4 in **Self-performance** and a 2 or 3 in **Support**? Check 'Yes' or 'No'.

P.2 If the answer to **P.1** is 'Yes' and CC.1 (Cognitive Capacity) is scored with a "1", score this section with a "1."

If **P.2** is scored with a "1," the person appears to be functionally and cognitively eligible for **Consumer Directed PCA Services**.

PHYSICALLY DISABLED WAIVER

PDW.1 Is person medically eligible for NF Level of Care (NF.7 on page 6 of 6 under Eligibility Determination)? Check 'Yes' or 'No'.

PDW.2 If the answer to **PDW.1** is 'Yes' and CC.1 (Cognitive Capacity) is scored with a "1", score this section with a "1."

If **PDW.2** is scored with a "1," the person appears to be functionally and cognitively eligible for **Physically Disabled Waiver Services**.

ELIGIBILITY DETERMINATION (p.4 of 6)

Header includes the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #, and Assessment Date.** THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE.**

ADULT FAMILY CARE HOMES**LEVEL 1****AF.1 Cueing/ Limited Assistance**

1.a. In **Section E., Physical Functioning/Structural Problems**, check "yes" if **d, e, f, and 4** (dressing, eating, toilet use and bathing) **all** were coded with a "5" (cueing required 7 days a week) in **Self-Performance** AND a "2," "3," or "5" in **Support**.

1.b. In **Section E., Physical Functioning/Structural Problems**, check "yes" if 2 or more of the following 7 ADLs: bed mobility, transfer, locomotion, eating, toilet use, bathing, dressing, were coded with a 2, 3, or 4 in **Self-performance** AND a 2 or 3 in **Support**?

If the answer to EITHER of these questions is "yes," score this section with a "1." The person appears to be eligible for **Level 1 Adult Family Care Homes**.

LEVEL 2**AF.2 Extensive Assistance**

2.a. In **Section E., Physical Functioning/Structural Problems**, check "yes" if at least one ADL from the following 5 ADLs: bed mobility, transfer, locomotion, eating, toilet use, was coded with a 3, or 4 in **Self-performance** AND a 2 or 3 in **Support**? **and**

2.b. In **Section E., Physical Functioning/Structural Problems**, check "yes" if 2 additional ADLs from the following 5 ADLs: bed mobility, transfer, locomotion, eating, toilet use, were coded with a 2, 3, or 4 in **Self-performance** AND a 2 or 3 in **Support**?

If the answer to BOTH of these questions is "yes," score this section with a "1." The person appears to be eligible for **Level 2 Adult Family Care Homes**. If the answer to one or more questions is "no," proceed to **AF.3 Cognitive impairment**.

AF.3 Cognitive impairment

3a. Is **Section C.1.a.** (short-term memory) coded with a "1"? Check 'Yes' or 'No'

3b. In **Section C.2.** (memory recall) are 1 or 2 boxes checked in C.2.a through C.2.d or is C.2.e., None of the Above, checked (Person is able to recall no more than 2 items)? Check 'Yes' or 'No'

3c. Is **Section C.3** coded with a "2" or "3"? Check 'Yes' or 'No'

3d. In **Section E, Physical Functioning/Structural Problems**, are 2 or 3 ADLs from the following 5 ADLs: bed mobility, transfer, locomotion, eating, toilet, coded with a 2, 3, or 4 in **Self-performance** AND a 2 or 3 in **Support**? Check 'Yes' or 'No'

If the answer to ALL of these questions is "yes," score this section with a "1." The person appears to be eligible for **Level 2 Adult Family Care Homes**. If the answer to one or more questions is "no," proceed to **AF.4 Behavioral Symptoms**.

AF.4 Behavioral Symptoms

4.a. In **Section D, Problem Behavior**, are one or more of the behaviors from items a, b, and c (wandering, verbally abusive, physically abusive) coded with a '2' or '3'?

OR are at least 3 of the behaviors from items **a, b, c, and d** (wandering, verbally abusive, physically abusive, socially inappropriate/disruptive behavior) coded with a '1' (behavior of this type occurred on 1-3 days only)?

4.b. In **Section E, (Physical Functioning/ Structural Problems)**, are 2 or 3 ADLs from items **a, b, c, e, and f** (bed mobility, transfer, locomotion, eating, or toilet use), coded with a '2', '3', or '4 in self-performance and coded with a '2' or '3' in support?

If the answer to BOTH of these questions (4a and 4b) is "yes," score this section with a "1." The person appears to be eligible for **Level 2 Adult Family Care Homes**.

LEVEL 3**AF.5 Cognitive Impairment**

5.a. Is **Section C.1.a.** (short-term memory) coded with a "1"? Check 'Yes' or 'No'

5.b. In **Section C.2.** (memory recall) are 1 or 2 boxes checked in C.2.a through C.2.d or is C.2.e., None of the Above, checked (Person is able to recall no more than 2 items)? Check 'Yes' or 'No'

5.c. Is **Section C.3** coded with a "2" or "3"? Check 'Yes' or 'No'

5.d. In **Section E, Physical Functioning/Structural Problems**, are at least 4 ADLs from the following 5 ADLs: bed mobility, transfer, locomotion, eating, toilet, coded with a 2, 3, or 4 in **Self-performance** AND a 2 or 3 in **Support**? Check 'Yes' or 'No'

If the answer to ALL of these questions is "yes," score this section with a "1." The person appears to be eligible for **Level 3 Adult Family Care Homes**. If the answer to one or more questions is "no," proceed to **AF.5 Behavioral Symptoms**.

AF.6 Behavioral Symptoms

6.a. In **Section D, Problem Behavior**, are one or more of the behaviors from items a, b, and c (wandering, verbally abusive, physically abusive) coded with a '2' or '3'?

OR are at least 3 of the behaviors from items **a, b, c, and d** (wandering, verbally abusive, physically abusive, socially inappropriate/disruptive behavior) coded with a '1' (behavior of this type occurred on 1-3 days only)? Check 'Yes' or 'No'

6.b. In **Section E, (Physical Functioning/ Structural Problems)**, are at least 4 ADLs from items **a, b, c, e, and f** (bed mobility, transfer, locomotion, eating, or toilet use), coded with a '2', '3', or '4 in self-performance and coded with a '2' or '3' in support? Check 'Yes' or 'No'

If the answer to BOTH of these questions (6.a and 6.b) is "yes," score this section with a "1." The person appears to be eligible for **Level 3 Adult Family Care Homes**.

ELIGIBILITY DETERMINATION (p.5 of 6)

Header includes the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #, and Assessment Date.** THE INFORMATION IN THE HEADER CONNECTS EACH SECTION OF THE FORM AND **MUST BE COMPLETED ON EACH PAGE.**

AT-RISK PRIVATE DUTY NURSING

- R.1 Private Duty Nursing:** Check "yes" to any **Section A, Nursing Services** coded with a "1", "2", "3", or "5" as specified in **R.1, a, b, c, d, and e.** (Note the addition of item e, "In **Section A, was item 13, Assessment/ Management, coded with a 1 (assessment needed once a month)?**") If the answer is "yes" to any of these questions, then score "1" in the box.
- R.2 Professional Nursing Services:** Check "yes" if any of the boxes in **Section B.1 and B.2 Special Treatments and Therapies** are coded with a "1", "2", or "3". If the answer is "yes," then score "1" in the box.
- R.3 Impaired Cognition:** Check "yes" or "no" on each question, **a through d.** If **all** of the answers to the questions are "yes," then score "1" in the box.
- R.4 Problem Behavior :** Check "yes" or "no" on questions **a and b.** If the answer to **both** questions is "yes," then score "1" in the box.
- R.5 Total At-Risk Nursing Score:** Compute the **Total "At-Risk" Nursing Score** from Boxes **R.1, R.2, R.3, and R.4.** Place the total score in the box. If this total "At-Risk" nursing score is "1" or more, proceed. Otherwise the person appears **NOT** to be medically eligible for "At-Risk" level of care.
- R.6** In **Section E., Physical Functioning/Structural Problems,** check "yes" if **d, e, f, and 4** (dressing, eating, toilet use and bathing) **all** were coded with a "5" in **Self-Performance AND (NOTE CHANGE): a "2," "3," or "5" in Support.**
- R.7** In **Section E., Physical Functioning/Structural Problems,** check "yes" if 2 or more of the following 7 ADLs--bed mobility, transfer, locomotion, eating, toilet use, bathing, dressing --were coded with a 2, 3, or 4 in **Self-performance AND a 2 or 3 in Support?**
- R.8 "At-Risk" ADL Needs Score:** If the answer to either **R.6 or R.7** is "yes" then score "1" in the box.
- R.9 "At-Risk" PDN Eligibility Determination (R.5+R.8)**
- a.** In **R.5,** is the score for "At-Risk" nursing services "1" or more? Check "yes" or "no"
 - b.** In **R.8,** is the score for "At-Risk" ADL needs "1"? Check "yes" or "no".

If the answers to questions **a.** and **b.** are "yes" then score "1" in the box: the person appears to be medically eligible for **"At-Risk" PDN level of care.**

Otherwise, the person appears **NOT** to be medically eligible for "At-Risk" level of care.

MEDICATION SERVICES FOR PERSONS WITH SEVERE AND DISABLING MENTAL ILLNESS

R.10.

- a. Check 'Yes' if there is a physician certification in the person's record verifying the person's eligibility or coverage for services under Section 17 of the Maine Medical Assistance Manual, for Severe and Disabling Mental Illness. If the person has not been certified under Section 17 but would be covered according to physician, then this can be checked 'Yes'.
- b. Check 'Yes' if physician has certified that use of outpatient services is contraindicated for this person.

If the answer to both of these questions is 'Yes', then enter a '1' in the box.

R.11.

- a. Check 'Yes' if Section G1a, Medication Preparation/Administration, is coded with a '6'.
- b. Check 'Yes' if Section G1b, Medication Compliance, is coded with a '4'.

If the answer to either of these questions is 'Yes', then enter a '1' in the box.

If both R.10 and R.11 are scored with a '1' then person appears eligible for Medication Services under the PDN program. Otherwise, the person appears **NOT** to be medically eligible for Medication Services.

VENIPUNCTURE ONLY SERVICES

R.12.

- a. Check 'Yes' if there is a physician order in the person's record for **ONLY** venipuncture services on a regular basis.
- b. Check 'Yes' if physician has certified that use of outpatient services is contraindicated for this person.
- c. Check 'Yes' if Section B1e, Venipuncture, is coded with a 1, 2, or 3.

If the answers to R.12 a., b., and c. are 'Yes' then enter a '1' in the box. Person appears eligible for Venipuncture Only Services under the PDN program. Otherwise, the person appears **NOT** to be medically eligible for Venipuncture Only Services.

ELIGIBILITY DETERMINATION (p. 6 of 6)

Header includes the following items: **Agency Name, Provider-Assessor #, Applicant Name, Social Security #, and Assessment Date.** This section will assist the assessor in making a determination of nursing facility medical eligibility.

NURSING FACILITY LEVEL OF CARE

NF.1 Nursing Services Check “yes” to any nursing services coded with responses as specified in the box. If the answer is “yes” to any of these questions, then the person appears to be medically eligible for nursing facility level of care. Sign the form and proceed to **COMMUNITY OPTIONS.** If the answer is “no” to all questions in **NF.1**, proceed to **NF.2, Professional Nursing Services.**

NF.2 Professional Nursing Services

Section A., Nursing Services and Therapies. Enter the number of conditions or treatments in items 1-8 that required nursing services 3-6 times a week. Enter 1 for “yes” if the total number of days of therapy was 3 or 4 days a week.

Section B, Conditions and Procedures. Enter 1 for “yes” if you coded any of the responses with a “2” (service needed 3 or more days per week) for items 1a-1e and 1g-1j (**excluding 1.f monthly injections**) and items 2a -2d. Compute the nursing services score and enter the total in Total box. Proceed to **NF.3.** If no conditions or treatments are checked, enter “0” in Total box and proceed to **NF.3, Impaired Cognition.**

NF.3 Impaired Cognition

a. Is Section **C.1.a.** (short-term memory) coded with a “1”? Check ‘Yes’ or ‘No’.

b. In Section **C.2.** (memory recall) are 1 or 2 boxes checked in C.2.a through C.2.d or is C.2.e., None of the Above, checked (Person is able to recall no more than 2 items)? Check ‘Yes’ or ‘No’.

c. Is Section **C.3** coded with a “2” or “3”? Check ‘Yes’ or ‘No’.

d. [Is Section **C.4.A** coded with a “1”] **OR** [in **Section E**, is at least one shaded ADL coded with a “2,” “3,” or “4” in self-performance and a “2” or “3” in support **AND C.4.B** (from page 2A **Supplemental Screening Tool**) is “13” or more]? Check ‘Yes’ or ‘No’.

If all the answers to the above questions are “yes”, then score this section with a “1.” Proceed to **NF.4, Behavior Problems.**

NF.4 Behavior Problems

a. In Section **D**, are one or more of the behaviors from items **a-d** (wandering, verbally abusive, physically abusive, socially inappropriate behavior) coded with a “2” or “3”?

b. [Is Section **D.2.A.** coded with a “1”] **OR** [in **Section E**, is at least one shaded ADL coded with a “2,” “3,” or “4” in self-performance and a “2” or “3” in support **AND D.2.B** (from page 2A **Supplemental Screening Tool**) is “14” or more]?

If the answer to both questions is “yes,” then score this section with a “1.”

NF.5 Total the scores from **NF.2**, **NF.3**, and **NF.4**. Place the total in the **Total Nursing** box. If the **Total Nursing Score** is "1" or more, proceed to **NF.6**. If the **Total Nursing Score** is "0", the person appears **not** to be medically eligible for nursing facility level of care.

NF.6 Determining the **Total ADL Needs** from **Section E (Physical Functioning/Structural Problems)**: the shaded ADLs --bed mobility, transfer, locomotion, eating and toilet use-- must be coded with a "2", "3" or "4" in Self Performance AND ALSO require a one or more physical assist (i.e., Support must be coded with a "2" or "3"). See example.

ADL Needs

| | Self-Performance | Support |
|--------------|-------------------------|----------------|
| Bed Mobility | 2 | 1 |
| Transfer | 3 | 2 |
| Locomotion | 2 | 2 |
| Eating | 3 | 3 |
| Toilet Use | 2 | 1 |

In the example above, the **Total ADL Needs** would equal "3" because three ADLs (transfer, locomotion and eating) had a **Self-Performance** code of "2" and "3" and had a corresponding **Support** code of either "2" or "3."

NF.7 Total Nursing and ADL Needs Score (NF.5 + NF.6)

Total the numbers from **NF.5** and **NF.6** and place in the appropriate box. If the **Total Nursing and ADL Needs Score** is "3" or more, the person appears to be medically eligible for nursing facility level of care. Otherwise, the person appears not to be medically eligible. Proceed to the Careplan summary unless the person has requested Extended PDN services.

EXTENDED PDN

EXP.1 In **Section A**, was item 9 (Ventilator/ Respirator) coded with a "4" (nursing services needed 7 days a week)? Check "yes" or no".

If the answer is "yes," then person appears to be medically eligible for **Extended PDN**. Score "1" in the box. If the answer is "no," then proceed to **EXP.2**.

EXP.2

2a. In **Section A**, was one of the following items from 1 (Injections/IV Feeding), 2 (Feeding Tube), 3 (Suction / Trach Care), 4 (Treatment /Dressings), 8 (Comatose), or 10 (Uncontrolled Seizure), coded with a "6" (nursing service needed at least once every 8 hours, 7 days a week)? Check 'Yes' or 'No'.

2b. In **Section A**, were 2 additional items from 1, 2, 3, 4, 8, or 10 coded with a "4" (service needed at least 7 days a week)? Check 'Yes' or 'No'.

If the answer to **BOTH** 2.a and 2.b is "yes," then person appears to be medically eligible for **Extended PDN**. Score "1" in the box. If "no," then person appears **NOT** to be eligible for **Extended PDN**.

Paste coding sheet here

Refer to the coding sheet on the previous page when filling out this care plan summary.

COMMUNITY OPTIONS

SECTION S. CARE PLAN SUMMARY

Header Complete the following items: **Agency Name, Provider-Assessor #, Assessment Date, Applicant Name, Social Security.** Refer to the coding sheet on previous page when completing this care plan summary.

SUPPORT SERVICES

Informal support is care provided that is NOT reimbursed by a formal Program/funding source.

When hours of care are not being reimbursed, they should be entered in this section as informal support. Enter the hours on the appropriate row for the type of care provided

- **When family/friends are not being reimbursed for care they provide, those hours are listed here and also included on the careplan under Program/funding source = Other.**
- **When family/friends are being reimbursed for care they provide under an authorized program, those hours are not entered in this Support Services section. They are included on the careplan under the authorized Program/funding source.**

Example:

Live in granddaughter paid for 35 hours/week under Elderly Waiver

In addition she provides 10 hours/week ADL & IADL support that is not paid. The 10 hours would be documented in Section S.4, S.5, Support Services.

The 35 hours will be on the care plan summary, Section S.7 under the Elderly Waiver (#5)

The 10 hours will be on the care plan summary, Section S.7 under Other for program funding source (#20), Service Category = Family or Friend

1. Extent of help: for instrumental and personal activities of daily living received *over the last 7 days*, indicate extent of help from family, friends, and neighbors on a. 5 weekdays and b. 2 weekend days. Round hours of care.

2. Two Key Informal Helpers: Information on two family members, friends, or neighbors most relied on for help with ADLs or IADLs (or who could be relied on, if no one now helps with these activities.)

Name of Person 1 and Person 2

Complete A. and B. For items a. and b., note the information for Person 1 is recorded in the left column, and information for Person 2 is recorded in the right column.

3. Caregiver Status: Check all that apply from a, b, c, d, and/or e. Or check f. NONE OF ABOVE.

For **Person A**, complete the current number of weekday and weekend hours of help provided. Enter the number of hours provided in each category, Advice or emotional support, ADL care, IADL care, Supervision only. Is this person willing to increase the number of weekday hours? If “yes,” fill in the number of additional hours. Is this person willing to increase the number of weekend hours? If “yes,” fill in the number of additional hours. If person not willing to or able to increase hours, enter “0”. For each category, enter the extent of knowledge the caregiver has about that category: 0 = Full knowledge, 1 = Partial knowledge, 2 = No knowledge for that particular category.

Fill in the same information for **Person B**, if applicable.

MEDICARE/3RD PARTY PAYORS:

Indicate routine Medicare /Medicaid services in this block. For the **Medicare/ Third party Payor** Block, use the following codes: code 21 for Medicare, code 22 for 3rd party payors, such as BC/BS, Champus, VA, and LTC insurance, code 23 for Community Medicaid, code 24 for Consumer's Funds, or 25 for nursing facility. In most cases the assessor does not authorize services under these funding sources. This space is provided to record services recommended by the assessor or services being received that are reimbursed by Medicare/third party payors.

- 1. Funding Source:** Enter the payment code, 1 through 20, for the funding source that will pay for the recommended service.
- 2. Service Category:** Enter the appropriate code to indicate the service category recommended to meet the need. Be sure that the service category selected is reimbursable under the program/funding source.
- 3. Reason Code/Need met:** List all reasons for service. Be sure to match functional needs to level of service category.
- 4. Duration** Enter the **4a. Start Date** and **4b. End Date** for the proposed service.
- 5. Unit Code** Enter the unit of time that is used in calculating the cost of this service, using the codes 1 through 11. **NOTE: The unit code used on the careplan summary table must match the allowable unit codes for each policy and as required by the HCCA. Each Medicaid policy includes Chapter III, reimbursement codes and maximum allowances. Please refer to individual policy.**
- 6. Number of units per month** Enter the number of units needed *per month* to meet the person's needs.
- 7. Rate per unit:** Enter the current rate for this service based on the maximum allowable Medicaid rate for that specific unit of service in this program as found in the appropriate Medicaid manual.
- 8. TOTAL cost per month.** Add the numbers in column 8 and place total in box labeled **Medicare/3rd Party total.**

ALL OTHER FUNDING SOURCES/SERVICES PROVIDED:

- 1. Funding Source:** Enter the payment source that will pay for the recommended service. Codes 2 through 19 apply to many of the programs and code 23 for Community Medicaid that is required for At Risk PDN, Extended PDN, NF PDN, Consumer Directed PCA, Medicaid Day Health and in the future Assisted living.
- 2. Service Category:** Enter the appropriate code to indicate the service category recommended to meet the need and tasks identified in the assessment. **Be sure that the service category and unit of service selected is reimbursable under the program/funding source.**
If you have a question refer to the specific policy for the program.

3. Reason Code/Need met: List all reasons for service. Several reasons are combined to indicate a mix of the tasks identified as a need to be met in the assessment. Pay close attention to the codes chosen to assure that the reason a service(s) is recommended has been identified as a need in the assessment.

4. Duration Enter the **4a. Start Date** (this may differ from the eligibility date because of the due process requirement to give so many days notice to the recipient) and **4b. End Date** for the proposed service.

5. Unit Code Enter the unit of time that is used in calculating the cost of this service, using the codes 1 through 11 from the unit code list. **NOTE: The unit code used on the careplan summary table must match the allowable unit codes for each policy and as required by the HCCA. Each Medicaid policy includes Chapter III, reimbursement codes and maximum allowances. Please refer to individual policy. NOTE: The unit code used on the careplan summary table must match the allowable unit codes for each policy and as required by the HCCA. Each Medicaid policy includes Chapter III, reimbursement codes and maximum allowances. Please refer to individual policy.**

6. Number of units per month Enter the number of units needed *per month* to meet the person's needs.

7. Rate per unit: Enter the current rate for this service based on the maximum allowable Medicaid rate for that specific unit of service in this program as found in the appropriate Medicaid manual.

8. TOTAL cost per month. Add the numbers in column 8 and place total in box labeled **Other Funding Sources Total.**

Fill in the 8 columns for each service as described above for all other funding sources. Add the numbers in column 8 and place total in box labeled **Other Funding Sources Total.**

Sections T-Z: OUTCOME

Outcome Header Complete the following items: **Agency Name, Provider-Assessor #, Assessment Date, Applicant Name, and Social Security number.**

This section of the MED form communicates information about the medical eligibility outcome of the assessment and crucial dates that may start or end payment for services. It also tracks the reassessment due dates and appeal status when applicable. This is the page that must be sent to BMS for classification entry into the Welfre system to assure payment of claims.

Section T. Assessment Type/Version

1. Type. Indicate whether this is an initial or reassessment. The **initial assessment (1):** is the first assessment completed on a consumer triggered by a specific request. The **reassessment (2):** A consumer has an existing valid assessment due to expire and requires reassessment for determination of continued medical eligibility. A reassessment may also apply when a consumer chooses to transfer from one specific program or funding source to another program or funding source. A significant change in the consumer's condition, improvement or deterioration, may also trigger a reassessment. Reassessment replaces the term reclassification across all program and funding sources.

Reassess date due: Fill in the appropriate date based on the length of time of the prior medical determination. **PAYMENT ends with the reassessment date and will not continue without a reassessment to determine continued medical eligibility for the current program.**

2. Version: Any change to the original version of an assessment is labeled as a version. Changes may occur to the original version of the assessment, according to policy and procedural parameters. These may be triggered by a change in financial circumstances, a change in a consumer's choice of program or provider, a change in the status of the assessment based on due process and/or allowable revisions in the eligibility start and end dates when justified by certain circumstances. Any change to the "original" version is labeled a specific version as defined below.

Original (1): The original version of an assessment. Each assessment regardless of whether it is an initial or reassessment has an "original" version, the version completed at the time of the face-to-face assessment.

Revision (2): A change in the eligibility begin and end dates, or program begin and end dates or programs denied dates, or provider chosen, or data error may require a "revision" to the original assessment. The changes required are reflected in the "revision" version of the original assessment. **Conversion (3):** A change in either the funding/payment source or consumer's program choice or a transfer from awaiting placement in one location to another location for a specific program or funding source may result in a conversion of the original assessment outcome. Conversions **MUST** occur within 30 days of original assessment date. The change from the original assessment becomes the "conversion" version of that original assessment. This does **NOT** apply to a Medicare to Medicaid, 20 day Medicaid/Medicare to NF Medicaid or a Medicare to private pay assessment. It does apply to "awaiting placement status" across Medicaid funded programs.

Pending appeal (4): If an assessment is appealed, a version of the previous (expired) assessment must be created to allow for services to continue during the time due process is being considered. The change to reactivate the expired assessment is the "pending appeal" version of the expired assessment.

Reinstated (5): If the appeal outcome determines the consumer correct, a version of the expired assessment is created with a **90 day** reassessment date from the date of the final appeal decision. The change to “reinstate” the original assessment after successfully appealing an outcome is the “reinstated” version of that assessment. Reinstatement for any Medicaid decisions will be handled by the Department.

Update (6): The updating of the original assessment from advisory to specific program or funding source eligibility **MUST** occur within 30 days of original assessment. **ONLY** advisory LTC or Medicare to private pay assessments may be updated. On any updated version the Advisory plan in Section T “4” would be “0” for no because the consumer has made a choice. Any “update” of an assessment provides for a 90-day eligibility period from the date of the original assessment.

NOTE PROCESS CHANGE: Updates of Advisory assessments to NF Medicaid decisions will **NOT** occur until the consumer enters the NF and the assessing agency receives either a transfer form, fax or telephone referral request from the NF. If prior to admission to the NF, the assessing agency receives a BFI/ LTC message form, the assessing agency will complete the form with AP at home or hospital, with eligibility as of the assessment date and return the completed LTC (122) form to BFI. This alerts BFI that NF medical eligibility has been determined and BFI will proceed with financial eligibility determination. At admission to the NF, the original assessment is **updated** from advisory giving a 90-day reassessment date from the date of the original assessment. The assessing agency will send a LTC message form to BFI indicating the move from awaiting placement to NF admission, being sure to complete the change in address section to the NF address.

3. Column 1-Assessment requested: Column 1 records the assessment requested at the time of the referral and should match the request from Section A-6b background information.

Column 2-Program Eligibility: Column 2 records the program eligibility calculated and based on the clinical detail portion of the assessment. A consumer may be eligible for multiple programs. Please note that in the examples provided with this memo not all program eligibility may be reflected. When MECARE is implemented, the system will calculate and list all programs for which the consumer has been determined medically eligible. The assessor will with input from the consumer and within policy parameters authorize the appropriate programs.

4. Consumer choice: The consumer makes a choice based on the information provided to them by the RN assessor regarding program medical eligibility, services available and potential funding reimbursement sources for those services. Consumers are given the opportunity to make a choice for ALL assessments.

- **Community options (1)-** the consumer chooses to remain in the community and access available services based on medical and financial eligibility.
- **Residential care (2)-** the consumer chooses to enter or stay in a residential care facility This category includes Adult Family Care Homes as a choice. **ONLY** Adult Family Care Homes have medical eligibility requirements at this time.
- **Advisory Only (3)-** A consumer has requested an advisory assessment because they are looking to receive information about long-term care. From the assessment the consumer has received the information necessary to consider the options available and the financial implications based on the medical eligibility determination. Additional tasks or applications may be required to access a specific program or funding option. The assessment is advisory only.
- **No Choice (4)-** A consumer has requested an assessment for a specific reason and has received the medical eligibility outcome based on the assessment. At the time of the assessment, the person is unable to make a choice concerning their care.

- **Nursing facility (NF) (5)**- the consumer chooses to enter or stay in a nursing facility.

5. Advisory Plan:

Select “1” for Yes for advisory program referrals provided to the consumer. Select “0” for No for program referrals provided and chosen by the consumer that are authorized in Section Z-Community Program. Advisory plan is only checked “1” Yes for a plan that appears on the careplan summary page and is **not authorized** in Section Z on the outcome page.

For the 20 day Medicare/Medicaid assessment type, the consumer is currently receiving skilled nursing facility level of care. Projecting a recommended “advisory” plan of care at this time will not in most cases be appropriate. Conversion or updating of the 20 day Medicare/Medicaid assessment is not allowed.

Note: Advisory medical eligibility determination is valid for **30 days ONLY**. Enter the dates for which this medical eligibility determination is valid. Check 0 -NA if no advisory plan is given.

Section U. NF Medical Eligibility

Based on this assessment, is the person medically eligible for nursing facility level of care? Enter “0” for No, “1” for Yes based on the determination made on the scoring pages (NF.7 on page 6 of 6). This section must be completed on every assessment regardless of the version or outcome.

Section V. Awaiting Placement

Awaiting Placement: Only applies to a Medicaid decision, and requires a Medicaid number and/or notice that a financial application has been filed. Awaiting Placement status is approved by the Department’s authorized agent. Awaiting Placement is not available for consumers on program waiting lists, Advisory status assessments, or non-Medicaid applicants. Outcome pages for consumers awaiting placement (AP) in the hospital must be sent to BEAS for data entry to facilitate payment. This section indicates eligibility for a program and allows for reimbursement based on the location of the consumer. It also facilitates transfer from one program within a location to another program or the same program, at another location during the specified eligibility period. This section applies to consumers awaiting transfer from a hospital to a nursing facility or to one of the waiver programs, or from the community (home) to a nursing facility, or from a nursing facility to home or from out of state to Maine for nursing facility admission. It also applies to transfer of consumer from Medicaid Home Health program to Private Duty Nursing (PDN) program. Upon admission to the program the consumer has been awaiting placement for, a **conversion** of the assessment must be completed. When a conversion is completed the awaiting placement dates must be revised to indicate the last day of payment for the provider if applicable. The awaiting placement status is valid for 30 days. Valid medical eligibility ends with the last date of the valid period. Payment source for the facility (hospital or nursing home) or home health agency or provider, where the consumer received services while awaiting placement, also ends with the last date.

1.a. What program is the person awaiting placement for? Fill in “0” for NA, “1” for nursing facility, “2” for Medicaid Waiver, “3” for Private Duty Nursing (PDN). PDN is only available to consumers located at home who are currently receiving Medicaid Home Health services.

1.b. Where is the person currently located? This is the location where the person is awaiting to be placed from. Fill in “0” for NA, “1” for nursing facility, “2” for hospital, “3” for at home, or “4” for

out-of-state. Hospitals, nursing facilities and waiver providers may need to be reimbursed for services delivered during the awaiting placement time. For payment to the hospital to occur, the name of the hospital must be filled in. As soon as the transfer from one type or location of provider occurs, a transfer form must be forwarded to the ASA to assure transfer of reimbursement from one provider to another, or to start reimbursement as of admission to the program/funding source.

Hospital to NF or home to NF admissions: Upon consumer's admission to the nursing facility, the nursing facility will forward the transfer form to the Assessing Services Agency (ASA). An RN in central office or the RN assessor will complete the conversion assessment and return the converted outcome to the Department within 72 hours. Concurrently a new letter of eligibility that includes the eligibility start date and reassessment date will be issued to the consumer. A copy of the "converted" assessment (be sure to include all sections) and all other relevant paperwork will be forwarded to the nursing facility. A choice letter, signed on the day of the assessment, will also be sent to the facility.

1.c. Valid eligibility. Awaiting placement assessments are valid for 30 days. Enter the dates for which the person is eligible by filling in the start and end dates of eligibility or "0" if this is NA (not applicable). The validity of the medical eligibility determination ends with the end date indicated here. The valid eligibility dates will be revised when the awaiting placement ends and the original assessment is converted. For example: a consumer is determined awaiting placement for NF at the hospital with eligibility dates of August 1, 2001 to August 30, 2001. On August 10, 2001 the ASA receives a transfer form stating admission to Snowy Hill NF on August 11, 2001. The valid eligibility dates for awaiting placement would be revised on the conversion to August 1, 2001 to August 10, 2001. Remember a provider does not get reimbursed for date of discharge and does get reimbursed for day of admission. In this example, payment to the hospital ends on August 10, 2001 and starts for the NF on August 11, 2001. Be sure on the conversion to complete the appropriate dates in Section X.

Section W. NF/Hospital/Home Health Dates

These dates are closely linked to the referral process and must be completed to expedite timely completion of assessments.

1. **Acute care denial date.** This is the final date of payment by Medicare or other third party payor, for the person's acute hospital care. This date must be provided to the Department's authorized ASA for awaiting placement status to be determined and approved while a consumer is located in a hospital setting. Fill in the blank or select "0" NA. Example: TXZ hospital issued acute care denial on 7/01/01. Fill in blank with **July 1, 2001.**
2. **First Non-SNF date.** This is the first day of nursing facility care not covered by Medicare or other third party payor following skilled nursing facility (SNF) care. This is the date when another funding source must be available to pay for the person to remain in the nursing facility. Medicaid, private pay or other third party payors may be the source of reimbursement as of this date. The last funded Medicare date would be the day before this date. Fill in the blank or select "0" NA. Example: July 1, 2001 is the 100th day and last day of Medicare /other third party payor date and **July 2, 2001 is the first Non-SNF date.**
3. **Last day private pay.** This is the last day that the cost of nursing facility care will be covered by consumer's funds (includes long-term care insurance). Fill in the blank or select "0" NA. In most cases this may be an anticipated date from the NF as indicated by the family or other responsible party. It may also be a date defined by BFI on the LTC message form. Indicate if the date is anticipated: Last Day of private pay: **anticipated July 15, 2001.**
4. **Late notification date.** If a provider does not request a reassessment within the allotted time frame required by policy, the referral is considered late notification. Enter "1"- Yes or select "0"- No if the referral was not late or this is not applicable (NA). This indicates to the RN assessor and the provider that a timely assessment /reassessment has not been requested according to policy requirements and payment may be impacted. Lapse in eligibility dates will occur. Example: Reassessment due on August 1, 2001. Provider requests reassessment on August 10, 2001. Fill in box as **"1" for "yes" late notification.** If outcome indicates eligibility for a program, the eligibility start date = date of the assessment.
5. **Bed hold expired.** If a person enters the hospital from a nursing facility and the 10-day bed hold requested and allowed by policy expires, enter "1"- Yes or select "0" No if it has not expired or this is NA. A bedhold expires after a nursing facility has requested the bedhold and the consumer remains in the hospital beyond ten days (ten midnights), not returning to the nursing facility within this timeframe. Example: Eligible Medicaid consumer admitted to hospital from NF on August 1, 2001. Consumer to be discharged back to the NF as Medicaid on August 20, 2001. **Fill in box as "1" for "yes" bedhold expired. NFs should not readmit consumers without an assessment being done if their bedhold has expired.** However, if the consumer spends 10 midnights in the hospital and returns to the NF prior to the 11th midnight, the bedhold is not considered expired. Example: Consumer admitted to hospital on August 1, 2001 from the NF, returns to the NF on August 11, 2001. Assessment does not have to be done unless their Reassess Due Date occurred during their hospital stay.
6. **Home Health End date.** Fill in the last funded date of Medicaid Home Health. Example: Current certification period ends on September 30, 2001. Consumer now requires prior authorization. Fill in Home Health end date **09/30/01.**

Section X. NF Facility

- a. Entering NF** Will the person be entering a nursing facility? Select “0” for no or “1” for yes. Under the current assessing agency contract parameters, the Department expects that a consumer has decided to enter a specific NF, knows a bed is available and has an admission date and is requesting the Long Term Care Advisory assessment to meet the State statute mandate.
- b. Currently in NF** Is the person currently in a nursing facility? Select “0” for no or “1” for yes.
- c.** If in a nursing facility, fill in the nursing facility name in the spaces provided. If entering a nursing facility and the assessor knows which facility, fill in the nursing facility name in the spaces provided.
- d. Eligibility start date.** Fill in the appropriate date for when medical eligibility starts based on the assessment type, version and outcome, and other policy or contract requirements.
- e. Reassess date.** Fill in the appropriate date based on the length of time that this medical determination will be considered valid. **PAYMENT ends with the reassessment date.** In some cases, this date may be extended to allow for due process as the result of a denial of medical eligibility. A pending appeal version of the assessment will be provided to assure and authorize continued reimbursement during the appeal period when a timely appeal has been filed.
- f. End date.** Fill in the appropriate date. An End date is only given for those on Community Medicaid whose medical eligibility determination is valid for 30 days. Community Medicaid provides up to **30 days** of nursing facility care without requiring that the recipient’s financial eligibility be reviewed for nursing facility level of care. **This does not equate with reassessment date.** This assessment expires at the 30 day date unless the recipient has applied for a financial review. If notice is received by the ASA of the financial review request, a conversion assessment must be done to authorize continued medical eligibility. If a consumer has not applied to BFI within the 30 days and shortly does apply, and BFI requests an assessment, and the consumer is denied medical eligibility, Medicaid will not continue reimbursement to the nursing facility during the appeal period.
- g. Admission date.** Fill in the appropriate date based on person’s admission to the NF or select “0” NA for not applicable.

Section Y. Late Submission

This section allows the assessor to indicate why the assessment may not have been disseminated to the required parties within the required timeframe. Only certain reasons are acceptable and typically are defined by contract parameters.

- 1.a. Reason.** What is the reason that the submission of this assessment is late? Fill in “1” provider not chosen, “2” Financial pending, or “3” Consumer request.
- 1.b.** To what agency is the late submission being sent? Check all that apply: “a” BMS, “b” HCCA, “c” BEAS, or “d” Other.

Section Z. Community Eligibility

This table includes only program/funding sources that can be **authorized** by the Department's designated assessor, based on the medical eligibility determination **and** consumer choice of Community Options in Section T.4 (Choice = 1-Community Options). When consumer chooses other than Community Options in Section T, the recommended plan of care will not be entered in Section Z. The person may be eligible for services in the community, however has chosen to:

- 1) receive care in another setting
- 2) consider the recommended plan of care as advisory only or
- 3) make no choice.

Program/funding sources that are authorized by the assessor must be included in the chart provided. When completing another version of the assessment the same applies.

Fill in:

Program/ Funding source: This must agree with the medical eligibility determination and the consumer's choice and the careplan summary. There may be more than one program/funding source. Remember that there may be several service categories listed on the care plan summary page under one program/funding source. This table deals with the program/funding source only, that will provide reimbursement for the service categories listed under that program/funding source on the careplan summary.

(Note: The program/funding source for PDN Medication Services and PDN Venipuncture Only is #23 – Community Medicaid)

Provider: Fill in the provider name for the agency responsible for implementing the plan of care under the program funding source selected. Example: Elderly waiver, the provider is EIM. PDN for Venipuncture, the provider is the Home Health Agency name actually delivering this service.

Eligibility Start date: This date indicates the date that the services authorized may begin and have been approved for by the medical eligibility determination outcome. This date may differ from the eligibility date or assessment date to meet any due process required by policy. This date may also change from the original version to a conversion or revision assessment.

Reassess date: This date is the date that the medical eligibility ends and becomes invalid. Essentially the medical eligibility determination to access services expires. For care to continue and the provider to receive reimbursement for services delivered, an assessment is required to determine continuing medical eligibility. **PAYMENT ends with the reassessment date.** In some cases, this date may be extended to allow for due process as the result of a denial of medical eligibility. A pending appeal version of the assessment will be provided to assure and authorize continued reimbursement during the appeal period.

Wait list: If the person has been added to a waiting list for a specific program/funding source, the RN or other assessor will check the corresponding "wait list" box.

Residential Care

If the person chooses residential care and the medical eligibility is required for that type of Residential Care, complete the chart that is provided. If the consumer chooses residential care that does not require medical eligibility fill in the name of the facility in the provider column and enter N/A for the remaining columns. Currently only Adult Family Care Homes have medical eligibility requirements.

Programs Denied

If the person has been denied eligibility or received a reduction in services for any program/funding source, for which the assessor has the ability to authorize services and eligibility, complete this chart. **Do Not** complete this chart for Advisory Only assessment types. Use the codes found on the Community Options coding sheet. Fill in:

Name of Program: Indicate here the program/ funding source for which the eligibility has been denied or services have been reduced. Example, for program assessment requests 13 to 21 use 25- Nursing facility.

Action: Indicate here the action code that best matches the reason for denial of eligibility or reduction in services. Example: CNA changed to PCA – use “6” – Service Category Change.

Reason: Indicate the reason code for the denial or reduction in services. NOTE new Reason Codes to be used for reductions/denials/terminations. Example: CNA changed to PCA- use “16” – Change Type of Care Provider.

“10-day”: If the consumer is entitled to the 10-day appeal rights and services have to continue for the length of the 10 day notice to meet the due process requirement as required by policy Check “yes.”

Discharge date: Fill in the denial of eligibility date or the end of authorized payment date for the type of assessment requested. For programs where only the 60-day appeal notice applies or a 10-day notice for initial assessments (BEAS homemaker, HBC etc.), the discharge date column equals the date of denial date. Example: Initial assessment on 7/1/01 for HBC, eligibility denied - the date in this column is 7/1/01. For reassessment of program eligibility where the program denied requires the 10 day and/or 60 day notice, the discharge date column indicates the 10 day date or end of authorized payment for the program to allow for due process. Example: For a Medicaid NF reassessment due 7/1/01 and denied medical eligibility the date in this column is 7/10/01. The discharge date applies to the actual date (10 days from the assessment date) when a reduction or change in services will be implemented.

Discharge To: This column has been grayed out and does not need to be filled in at this time.

Notice Dates: If the person is being denied eligibility for a particular program or has a reduction in services, the assessor will complete the following items:

Date of denial: date of denial is the same date as the date of the assessment. Example: assessment completed on a reassessment for NF Medicaid medical eligibility July 1, 2001. Date of denial is: July 1, 2001.

10-day appeal date: Check the box when applicable and if checked, fill in the ten-day date. Date of the notice equals day one of the 10-day notice. Using example above, 10-day date = July 10, 2001.

60-day appeal date: Check the box when applicable and if checked, fill in the 60-day date. Date of the notice equals day one of the 60-day notice. Using example above, 60-day date = August 29, 2001.

APPEAL: For any Medicaid program, department staff will check the appeal box when an appeal is received. For non-Medicaid programs, the Department who receives the appeal will check the appeal box when an appeal is received. When an appeal is received that requires continuation of services during the appeal process, the appropriate person will complete a “pending appeal” version of the expired assessment and disseminate the information to **ALL** required parties.

Reinstate: When the appeal final decision is rendered and received by the Department, the reinstate box will be completed. If the consumer is successful in overturning the Department or authorized

agency's assessment, a "1" for Yes will be entered in the box. If required, a reinstated assessment version will be completed and disseminated to ALL required parties.

Date: Fill in the date that the final decision was rendered and impacts on the reinstatement of services.

Signature Enter the Assessment date, enter the version of this assessment, sign the form, and enter the date of your signature. The assessment date for versions of the original will be the same as the date of the original assessment. The version type of assessment indicated here should match the version type in Section T.2. The signature date however indicates the date that the original assessment was updated, converted, revised, reinstated or considered a pending appeal by the allowable party as defined by policy or process.

MEDICAL ELIGIBILITY DETERMINATION FORM (MED)

APPENDIX

- A. Nursing Home Eligibility / Transferring Assets / Medicaid Estate Recovery**
- B. Getting Help from the Medicaid Waiver: Nursing Care Services in the Home**
- C. Getting Help for Nursing Care Services in a Nursing Home**
- D. Cost of Care: Nursing Facility / At Home / Elderly Waiver or Adults with Disabilities Waiver**
- E. Patient Self- Determination Act**
- F. ADL Scoring Examples**
- G. TASK TIME ALLOWANCES**
- H. PDN MEDICATION AND VENIPUNCTURE SERVICES ONLY**

APPENDIX A - MEDICAID Estate Recovery

Important Information about Nursing Home Eligibility, Transferring Assets, and MEDICAID Estate Recovery

To get help from Medicaid, the person must meet both medical and financial rules for eligibility.

Medical

He/she must be found to be in need of the level of medical care given in a nursing home.

Financial

For financial eligibility, many criteria must be met. The person should be prepared to provide a complete financial history for the past 36 months. When he/she has money in a trust, the financial history will go back 60 months.

How long will this take?

Processing a Medicaid application can be complicated and time consuming. Once all needed records are received, the Department will see if the person can get help retroactive to the date he/she first filed a financial application and was determined eligible for nursing home care. Payment of nursing home care cannot go back before both of these criteria are met.

What happens to the client's income?

If the person gets help with his/her nursing home bill, the Department will tell him/her how much is needed to pay the nursing home each month. This cost of care is based on gross monthly income with adjustment made for health insurance payments, unpaid medical bills not covered by the nursing home or Medicaid, money needed for spouse or dependents, and \$40 per month for personal needs.

Important Things the Person Should Know About Giving Away or Transferring Assets (as of 1/1/00)

If the person transferred or gave away anything of value and did not get something of equal value in return, Medicaid may not be able to help him/her with the cost of nursing care bills.

A **transfer** is about anything of value, such as money, stocks, bonds, or property, that is given to anyone but your spouse, for example, to a relative, friend, or to a trust fund. This rule also applies if your spouse transferred anything.

The length of time that Medicaid will not help the person to pay for nursing care bills is called a **penalty period**. It is equal to the number of months the person could have paid for nursing home costs if he/she had not transferred that asset. The length of the penalty period depends on the value of the money or property given away. The penalty period starts with the month the person gave away the asset.

To see if there will be a penalty, Medicaid checks assets going back 3 years to make sure the person received full value for any asset that s/he or a spouse transferred. If the transfer involved a trust, Medicaid will look back 5 years. If the person or their spouse has set up a trust the Department needs to see a copy of this.

Here is an example of how we set the penalty period. Let's say the person gave his/her home valued at \$80,000 to a son in March 1999. Because the son had helped out over the years he did not

give the person any money in return for the home. This is called a **transfer of assets** for which the person did not get the fair market value (\$80,000) in return. Medicaid would not help to pay nursing care bills for 20 months starting in March 1999. This means the person could not get help until November 2000.

This is how the penalty period of 20 months is set: \$80,000 (value of the transfer), divided by \$3,917 (average private pay rate at a nursing home), equals 20 months. If this home were worth \$135,000, the penalty period would last for 34 months. There is no penalty for any transfer made 3 years before the person applies for Medicaid and is in a nursing home (or applies for nursing care at home.) If s/he transfers money to a trust, there is no penalty when this is done 5 years before s/he applies for Medicaid and is in a nursing home or applies for nursing care at home. However, some money in a trust may be counted toward the \$2,000 limit on resources.

The following is a list of transfers that do not have a penalty period.

| Exempt Transfers | | If the asset is: | |
|------------------|--|------------------|-------------|
| | | Home | Other Asset |
| 1. | To the individual's child under age 21 | X | |
| 2. | To the individual's child older than age 21 if s/he lived with person for 2 years before going to nursing facility, which allowed the individual to stay at home | X | |
| 3. | To a sibling with equity interest in the home and who lived there 1 year prior to nursing facility admission | X | |
| 4. | To the individual's child of any age if s/he meets SSI rules for disability/blindness | X | X |
| 5. | To a trust solely for the individual's SSI disabled/blind child | X | X |
| 6. | To a trust solely for an SSI disabled individual younger than age 65 | X | X |
| 7. | Assets that were transferred are returned | X | X |
| 8. | Assets transferred to or for the benefit of the community spouse | X | X |
| 9. | Assets transferred before 36/60 months of applying and in a nursing facility | X | X |
| 10. | Assets transferred for fair market value | X | X |
| 11. | Assets intended to be transferred for fair market value | X | X |

Medicaid Estate Recovery

The Medicaid Estate Recovery Law (22 M.R.S.A. ss 14 sub-ss 2-10) was enacted on July 1, 1993. It states in part that the State has a claim against the estates of certain Medicaid recipients at the time of their death.

Who is affected by this law?

This law involves estates of recipients who are included in one or more of the following descriptions:

1. Property or other assets are discovered that existed and were owned by the recipient and disclosure of the property or assets at the time benefits were paid would have rendered the recipient ineligible to receive the benefits.
2. It is determined that the recipient was 55 or older when that recipient received Medicaid assistance.
3. It is determined that the recipient had received or is entitled to receive benefits under a long-term care insurance policy and medical assistance was paid on behalf of the recipient for nursing facility or other long-term care services.

What time periods are involved?

For recipients who fit into the second or third categories above, the recipients must have been 55 years of age or older when they passed away on or after October 1, 1993. Only those payments made by Medicaid on or after October 1, 1993, will be included in the State's claim.

Are there any exceptions?

The law states that no claim may be made if there is a surviving spouse, or dependent under the age of 21 or disabled, or only service from Medicaid is the Medicare Buy-in.

How does the State get money from a claim?

The State does not "take" homes and does not take over property. The law states that the State's claim may be enforced using the following method(s):

1. The State may file a claim using procedures set forth in the Probate Code in the appropriate probate court. The State becomes a creditor with an established position behind certain exemptions and other creditors. When the estate is settled, the State's claim is satisfied in whole or in part.
2. The State may file a claim in the appropriate court to recover from assets or resources not included in a probated estate.

What if I have questions about this law or how it affects me? The number for the Estate Recovery Unit is 1-800-321-5557 or for specific caseworkers 287-6592 (A-K), 287-1944 (L-Z). Also, it is recommended that you seek qualified professional advice when deciding how to handle matters regarding estate planning.

APPENDIX B - Medicaid Waiver

Getting Help from the Medicaid Waiver: Nursing Care Services in the Home

This appendix explains the general financial rules for Medicaid coverage if the person lives at home and needs nursing home level of care.

Medicaid can help pay the cost of nursing care at home if the person's income and resources are less than the limit set by Medicaid. This program gives some nursing care services, usually four to eight hours per day, if the person needs nursing home level of care but stays at home.

If the person gets Medicaid and is age 55 or older, the State will make a claim on his/her estate to recover the money that Medicaid has paid for his/her care.

No claim will be made if the:

- person is survived by a spouse
- person is survived by a child who is under age 21 or disabled
- only service from Medicaid is Medicare Buy-in

For more information about Estate Recovery, call 1-800-321-5557.

Income Rules

Gross income (before any deductions for Medicare or other expenses) is used in determining eligibility. Income includes Social Security, veteran's benefits, pensions, unemployment compensation, annuity benefits, interest on assets, etc.

Monthly gross income of the individual must be less than \$1590.

Resource Rules

Resources that are normally **included** (are counted) when determining eligibility are:

- * retirement accounts
- * certificates of deposit
- * insurance settlements
- * whole life insurance totaling more than \$1,500
- * lump sum payments, such as gifts, inheritances, lottery winnings, and accumulation of income
- * mortgages or promissory notes
- * real estate other than the primary residence
- * savings bonds
- * savings and checking accounts
- * stocks, bonds, and mutual funds
- * trusts
- * vehicles not otherwise excluded

Items that are normally **excluded** (not counted) when determining eligibility are:

- * the home that is the primary residence
- * term life insurance
- * up to \$1,500 in whole life insurance

- * prepaid burial contracts (mortuary trusts)
- * burial accounts up to \$1,500 (reduced by the value of any prepaid burial contracts and whole life insurance)
- * real estate up for sale
- * SSI or Social Security retroactive payments are not counted for 6 months

The client's included (countable) resources that are in his/her name may not exceed \$2,000. There is no limit on the amount of resources that are in the spouse's name. Assets that are transferred or given away by the spouse or by the person to someone other than the spouse may result in Medicaid not paying for nursing care services for a certain period of time. This includes assets put into a trust. The more money that is given away, the longer the period of time that Medicaid will not pay for nursing care. At the time of application, the assets owned by the person and spouse will be looked at to see if any transfers have taken place over the last 3 years (over the last 5 years if money has been put into a trust). If client or spouse has set up a trust, the Department will need to see a copy.

Medical Need In addition to these financial rules, the person must be in need of the level of medical care given in a nursing home. To be eligible for Medicaid, the person must meet **BOTH** financial and medical rules.

Paying for the Consumer's Cost of Care If the person is eligible for a Medicaid waiver, each month he/she may have to pay part of his/her income toward the cost of care. The person may keep the following before paying the monthly cost of care:

- * \$895.00 for personal needs (depending on the specific waiver)
- * money to pay for the cost of medical insurance premiums and Medicare premiums
- * money to pay for some unpaid medical bills
- * funds to meet the needs of a spouse and some dependents

More monthly income may be kept by the person when he/she has a spouse living with him/her. The difference between the spouse's monthly income and \$540 per month is made up from the person's income.

The guidelines above for care in a nursing home and at home are effective 1/1/01. They may change at any time. The person should contact the local Medicaid office when help is needed to see if the rules have changed.

APPENDIX C - Nursing Home

Getting Help for Nursing Care Services in a Nursing Home

This appendix explains the general financial rules for Medicaid coverage if the person lives in a nursing home.

In addition to these financial rules, the person must be in need of the level of medical care given in a nursing home. This decision will be made by the Department and must be done before Medicaid will pay for any costs of nursing home care.

Even if the person is not applying for Medicaid and is living at home, this individual may ask to see if he or she is in need of nursing home level of care, either at home or in a nursing home. This is called an “advisory” opinion. Before anyone can be admitted to a nursing home, this advisory opinion must be done.

If the person gets Medicaid and is age 55 or older, the State will make a claim on his/her estate to recover the money that Medicaid has paid for his/her care.

No claim will be made if the person is survived by:

- person is survived by a spouse
- person is survived by a child who is under age 21 or disabled
- only service from Medicaid is Medicare Buy-in

For more information about Estate Recovery, call 1-800-321-5557.

Financial Rules

Income:

Gross income (before any deductions for Medicare or other expenses) is used in determining eligibility. Income includes Social Security, veteran's benefits, pensions, unemployment compensation, annuity benefits, interest on assets, etc.

Usually the income rules will be met if gross monthly income is under the monthly private rate for the facility in which the person lives. All sources of income are counted.

Resources:

Resources that are normally **included** (are counted) when determining eligibility are:

- * retirement accounts
- * certificates of deposit
- * insurance settlements
- * whole life insurance totaling more than \$1,500
- * lump sum payments, such as gifts, inheritances, lottery winnings, and accumulation of income
- * mortgages or promissory notes
- * real estate other than the primary residence
- * savings bonds
- * savings and checking accounts
- * stocks, bonds, and mutual funds
- * trusts

- * vehicles not otherwise excluded

Items that are normally **excluded** (not counted) when determining eligibility are:

- * the home that is the primary residence
- * up to \$4,500 of the value of a vehicle
- * term life insurance
- * up to \$1,500 in whole life insurance
- * prepaid burial contracts (mortuary trusts)
- * burial accounts up to \$1,500 (this is reduced by the value of any prepaid burial contracts and whole life insurance)
- * real estate up for sale
- * SSI or Social Security retroactive payments are not counted for 6 months

The person's included (countable) resources may not exceed \$2,000. If the person has a spouse living in the community, he or she may keep \$81,960 in countable resources owned by the person, the spouse, or by both jointly. More may be kept depending on the spouse's income.

Resources or income that are transferred or given away by the spouse or by the person to someone other than the spouse may result in Medicaid not paying for nursing care services for a period of time. This includes money put into a trust. The more money that is given away, the longer the period of time that Medicaid will not pay for nursing care. At the time of application the assets owned by the person and his/her spouse will be reviewed to see if any transfers have taken place over the last 3 years (over the last 5 years if money has been put into a trust). If either person has set up a trust, the Department will need to see a copy of it.

Paying for the Cost of Care

If the person is eligible for Medicaid in a nursing facility, each month he/she must pay part of his/her income toward the cost of care. The person may keep the following before paying the monthly cost of care:

- * \$40.00 for personal needs
- * money to pay for the cost of medical insurance premiums and Medicare premiums
- * money to pay for some unpaid medical bills
- * funds to meet the needs of a spouse and some dependents, if their own income does not exceed guidelines.

When the person lives in a nursing facility but the spouse does not, an allowance may be made from the resident's income to help the spouse. The difference between the spouse's monthly income and \$1383 (up to \$2103, depending on shelter costs) is made up from the resident's income.

The guidelines above for care in a nursing home are effective 1/1/00. These may change at any time. For this reason, contact the local Medicaid office for information about specific assets and the current rules that are in effect.

APPENDIX D - Cost Of Care

Nursing Facility Cost of Care

To compute the cost of care in a nursing facility for a person whose gross monthly income is less than the nursing facility's monthly charges, deduct from his/her income the following: \$40.00 for personal spending needs, his/her monthly Medicare payment, payments for health insurance, unpaid medical bills, and spousal/dependent allocations. The amount remaining is the **Nursing Facility Cost of Care**.

Example:

| | |
|----------------|--------------------------------|
| \$1,000.00 | gross income |
| <u>- 40.00</u> | personal needs |
| 960.00 | |
| <u>- 45.50</u> | Medicare |
| 914.50 | |
| <u>- 50.00</u> | medical bill |
| \$ 864.50 | nursing facility Cost of Care* |

* 90% of all nursing facility admissions are single people (without a spouse). If the person is married, a monthly spousal allowance is deducted from the nursing facility cost of care.

Elderly and Physically Disabled / Adults with Disabilities Waivers: At Home Cost of Care

Individual Income- pays cost of care to the waiver agency, minus \$895 for personal needs (used to pay rent, food, etc.), spousal allocation, income needed to pay health insurance including Medicare, unpaid medical bills.

Example:

| | |
|-----------------|--|
| \$1,200.00 | gross income |
| <u>895.00</u> | personal needs (this dollar amount is 125% of the poverty level) |
| 305.00 | |
| <u>- 45.50</u> | Medicare |
| 259.50 | |
| <u>- 50.00</u> | medical bill |
| 209.50 | |
| <u>* 184.00</u> | |
| \$ 25.50 | cost of care to waiver |

*allocation to spouse is determined as follows:

The waived individual allocates to his/her spouse an amount equal to the difference between the spouse's monthly gross income and \$540.00 per month (SS standard).

Example:

| | |
|-----------------|-----------------------|
| \$540.00 | |
| <u>- 356.00</u> | spouse's gross income |
| \$184.00 | spousal allocation |

APPENDIX E - Patient Self-Determination

What Does The Patient Self-Determination Act Say?

The Patient Self-Determination Act of 1990 requires all Medicare and Medicaid provider organizations (specifically hospitals, nursing facilities, home health agencies, hospices, and prepaid health care organizations) to do five things:

1. *"provide written information" to patients at the time of admission concerning "an individual's right under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning...medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives";*
2. *"maintain written policies and procedures" with respect to advance directives (e.g., living wills and health care powers of attorney) and to "provide written information" to patients about such policies;*
3. *"document in the individual's medical record whether or not the individual has executed an advance directive";*
4. *"ensure compliance with the requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization"; and*
5. *"provide (individually or with others) for education for staff and the community on issues concerning advance directives."*

The Act also requires providers *"not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive."*

APPENDIX F - ADL Scoring Examples

Examples: ADL Self-Performance

Bed Mobility

Consumer was physically able to reposition self in bed but had a tendency to favor and remain on his left side. He needs frequent reminders and monitoring to reposition self while in bed.

Code = 1

Consumer received supervision and verbal cueing when using a trapeze for all bed mobility. On two occasions when arms were fatigued, he received heavier physical assistance of two persons.

Code = 1

Consumer usually repositioned himself in bed. However, because he sleeps with the head of the bed raised 30 degrees, he occasionally slides down towards the foot of the bed. On 3 occasions the caregiver helped him to reposition by providing weight-bearing support as he bent his knees and pushed up off the footboard.

Code = 3

Because of severe, painful joint deformities, consumer was totally dependent on two persons for all bed mobility. Although unable to contribute physically to positioning process, she was able to cue caregiver for the position she wanted to assume and at what point she felt comfortable.

Code = 4

Transfer

Despite bilateral above-the-knee amputations, consumer almost always moved independently from bed to wheelchair (and back to bed) using a transfer board he retrieves independently from his bedside table. On one occasion in the past week, caregiver had to remind consumer to retrieve the transfer board. On one other occasion, the consumer was lifted by a caregiver from the wheelchair back into bed.

Code = 0

Once someone correctly positioned the wheelchair in place and locked the wheels, the consumer transferred independently to and from the bed.

Code = 0

Consumer moved independently in and out of armchairs but always received light physical guidance of one person to get in and out of bed safely.

Code = 2

Transferring ability varied throughout each day. Consumer received no assistance at some times and heavy weight-bearing assistance of one person at other times.

Code = 3

Locomotion

Consumer ambulated slowly pushing a wheelchair for support, stopping to rest every 15-20 feet.

Code = 0

A consumer with a history of falling and an unsteady gait always received physical guidance (non-weight-bearing) of one person for all ambulation. Three nights last week the consumer was found in his bathroom after getting out of bed and walking independently.

Code = 2

Consumer ambulates independently, socializing with others and attending activities during the day. Loves dancing and yoga. Because she can become afraid at night, she receives one-person assist to walk her to the bathroom at least twice every night.

Code = 2

During last week consumer was learning to walk short distances with new leg prosthesis with heavy partial weight-bearing assistance of two persons. He refuses to ride in a wheelchair.

Code = 3

Dressing

Consumer usually dressed self. After a seizure, she received total help from two caregivers once during the week.

Code = 0

Caregiver provided physical weight-bearing help with dressing every morning. Later each day, as consumer felt better (joints were more flexible), she required caregiver assistance only to undo buttons and guide her arms in/out of sleeves every evening.

Code = 3

Eating

Consumer arose daily after 9:00 am, preferring to skip breakfast and just munch on fresh fruit later in the morning. She ate lunch and dinner independently in the facility's main dining room.

Code = 0

Consumer is blind and confused. He ate independently once caregiver oriented him to types and whereabouts of food on his tray and instructed him to eat.

Code = 1

Cognitively impaired consumer ate independently when given one food item at a time and monitored to assure adequate intake of each item.

Code = 5

Consumer with difficulty initiating activity always ate independently after someone guided her hand with the first few bites and then offered encouragement to continue.

Code = 2

Consumer with fine motor tremors fed self finger foods (e.g., sandwiches, raw vegetables and fruit slices, crackers) but always received supervision and total physical assistance with liquids and foods requiring utensils. Code = 3

Consumer fed self with caregiver monitoring at breakfast and lunch but tired later in day. She was fed totally by caregiver at supper (the evening meal).

Code = 3

For a consumer to be coded as totally dependent (“4”) in Eating, he or she would be fed all food and liquids at all meals and snacks (including tube feeding delivered totally by staff), and never initiate any subtask of eating (e.g., picking up finger foods, giving self tube feeding or assisting with procedure) at any meal.

Toileting Use

Consumer used bathroom independently once up in a wheelchair but received weight-bearing assistance to get into his wheelchair. Used bedpan independently at night after it was set up on bedside table. Code = 0

Consumer uses the toilet independently but occasionally required minor physical assistance for hygiene and straightening clothes afterwards. She received such help twice during the last week.

Code = 0

When awake, consumer was toileted every two hours with minor assistance of one person for all toileting activities (e.g., contact guard for transfers to/from toilet, drying hands, zipping/buttoning pants). She required total care of one person several times each night after incontinence episodes.

Code = 3

Obese, severely physically and cognitively impaired consumer receives a hooyer lift for all transfers to and from her bed. It is impossible to toilet her and she is incontinent. Complete toileting care is provided at least every 2 hours by two persons.

Code = 4

Personal Hygiene

Once grooming articles were laid out and arranged by caregiver, consumer regularly performed the tasks of personal hygiene. Code = 0

Consumer was able to carry out personal hygiene but was not motivated. She received daily cueing and positive feedback from caregiver to keep self clean and neat. Once started, she could be left alone to complete tasks successfully. Code = 1

Consumer required total daily help combing her long hair and arranging it in a bun. Otherwise she was independent in personal hygiene. Code = 3

Bathing

Consumer received verbal cueing and encouragement to take twice-weekly showers. Once caregiver walked consumer to bathroom, he bathed himself with periodic oversight.

Code = 1

On Monday, one caregiver helped transfer consumer to tub. On Thursday, consumer had physical help of one person to get into tub but washed himself completely.

Code = 2

Consumer afraid of hooyer lift. Given full sponge or bed bath by caregiver twice weekly. Actively involved in this activity.

Code = 3

For one bath, consumer received light guidance of one person to position self in bathtub. However, due to her fluctuating moods, she received total help for her other bath. Rationale: The coding directions for bathing state, "code for most dependent in self performance and support."

Code = 4

Code = 8: Activity did not occur during the entire 7-day period: Over the last seven days, the ADL activity was not performed by the consumer, or by caregiver or staff for consumer. In other words, the particular activity did not occur at all.

For example: The definition of Dressing specifies the wearing of street clothes. During the seven day period, if the person did not wear street clothing, a code of "8" would apply (i.e., the activity did not occur during the entire seven day period). Likewise, a person who was restricted to bed for the entire seven day period and was never transferred from bed would receive a code of "8" for Transfer.

APPENDIX G - Task Time Allowances

| TASK TIME ALLOWANCES - Activities of Daily Living | | | | |
|---|---|--|---------------------------|--|
| Activity | Definitions | Time Estimates | | Considerations |
| Bed Mobility | How person moves to and from lying position, turns side to side and positions body while in bed. | 5 – 10 minutes | | Positioning supports, cognition, pain, disability level. |
| Transfer | How person moves between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet). | 5 – 10 minutes <u>up to 15 minutes</u> | | Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer, cognition. Mechanical Lift transfer |
| Locomotion | How person moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair. | 5 - 15 minutes (Document time and number of times done during POC) | | Disability level, Type of aids used Cognition Pain |
| Dressing & Undressing | How person puts on, fastens and takes off all items of street clothing, including donning/removing prosthesis. | 20 - 45 minutes | | Supervision, disability, cognition, pain, type of clothing, type of prosthesis. |
| Eating | How person eats and drinks (regardless of skill) | 5 minutes 30 minutes 30 minutes | | Set up, cut food and place utensils. Individual is fed. Supervision of activity due to swallowing, chewing, cognition issues |
| Toilet Use | How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter and adjusts clothes. | 5 -15 minutes/use | | Bowel, bladder program Ostomy regimen Catheter regimen Cognition |
| Personal Hygiene | How person maintains personal hygiene. (EXCLUDE baths and showers) | Washing face, hands, perineum, combing hair, shaving and brushing teeth | 20 min/day | Disability level, pain, cognition, adaptive equipment. |
| | | Shampoo (only if done separately) | 15 min up to 3 times/week | |
| | | Nail Care | 20 min/week | |
| Walking | How person walks for exercise only <u>How person walks around own room</u> <u>How person walks within home</u> <u>How person walks outside</u> | Document time and number of times in POC, and level of assist is needed. | | Disability Cognition Pain Mode of ambulation (cane) Prosthesis needed for walking |
| Bathing | How person takes full-body bath/shower, sponge bath (EXCLUDE washing of back, hair), and transfers in/out of tub/shower | 15 - 30 minutes | | If shower used and shampoo done then consider as part of activity. Cognition |

| TASK TIME ALLOWANCES - IADL = Instrumental Activities of Daily Living | | | |
|---|--|--|---|
| Activity | Definitions | Time Estimates | Considerations |
| <u>Light meal, lunch & snacks</u> | Preparation and clean up | 5 – 20 minutes | Consumer participation; type of food preparation; number of meals in POC and preparation for more than one meal. |
| Main Meal Preparation | Preparation and clean up of main meal. | 20 - 40 minutes | Is Meals on Wheels being used? Preparation time for more than one meal and consumer participation. |
| Light Housework/ <u>Routine Housework</u> | Dusting, picking up living space Kitchen housework- put the groceries away, general cleaning Making/changing beds Total floor care all rooms and bathrooms Garbage/trash disposal Non-routine tasks, outside chores, seasonal | 30 min – 1.5 hr/week | Size of environment Consumer needs and participation. Others in household |
| Grocery Shopping | Preparation of list and purchasing of goods. | 45 min - 2 hours/week | Other errands included: bills, banking and pharmacy. Distance from home. |
| Laundry | Sort laundry, wash, dry, fold and put away. | In-home 30 minutes/load <u>2 loads/week</u> | Other activities that can be done if laundry is done in the house or apartment. |
| | | Out of home 2 hours/week | |

APPENDIX H - PDN Medication And Venipuncture Services Only

Section 96.02- 4D Medication and Venipuncture Services for Severely Mentally Disabled Persons

Section 96.02-4D allows for medication administration or monitoring services for a person who qualifies for the Community Support Services, Section 17, for Persons with Severe and Disabling Mental Illness. The recipient's eligibility shall be established by a completed "verification of eligibility form" described in Section 17, or otherwise by a signed certification by a physician that the recipient is eligible/covered under Section 17. Dated copies of this form/certification must be maintained in the recipient's record to verify eligibility for covered services. AND

A physician must sign and certify a statement that the recipient's medical condition prevents the safe use of outpatient services and is contraindicated (defined in 96.01-18) for specific reasons. The reasons must be listed and the likelihood of such a bad result must be probable or definite as opposed to possible or rarely. Reasons may include lack of services within a twenty (20) mile radius of the recipient's residence. Medicaid covers transportation to all Medicaid covered services; therefore lack of transportation does not qualify as an exemption.

The Provider Agency may determine medical eligibility for this level of services. In order to determine eligibility the following sections of the Med form must be completed.

The following sections of the MED tool must be filled out for Medication Services:

BACKGROUND INFORMATION (page 1 of 1):

SECTION HEADER (needs to be filled out on each page)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

All of page 1 must be completed. Be sure to complete the homebound status in Box 20.

CLINICAL DETAIL (page 3 of 5) MEDICATIONS & DIAGNOSIS:

Section F. MEDICATIONS LIST: expectation that a medication prescribed for the treatment of severe and disabling mental illness will be present

Section G. MEDICATION: Additional codes for these 2 programs have been added under 1a. Preparation and Administration and 1b. Compliance.

1a. Preparation and Administration: # 6 - person requires administration of medications due to severe and disabling mental illness - would be entered into the box and/or

1b. Compliance : #4 - person requires monitoring of medications due to severe and disabling mental illness - would be entered into the box.

Section H. DIAGNOSES: expectation to see a Severe and Disabling Mental Illness diagnosis listed under Psychiatric/mood or listed in the other current diagnoses.

ELIGIBILITY DETERMINATION (page 2 of 4):

Section R10: MEDICATION SERVICES FOR PERSONS WITH SEVERE & DISABLING MENTAL ILLNESS: Complete the box by answering the questions and scoring appropriately.

COMMUNITY OPTIONS - CARE PLAN SUMMARY (page 1 of 1):

MEDICARE/3RD PARTY PAYORS: Box 6: Medicare/3rd party payors: recipients with a Community Medicaid card may receive these services if determined medically eligible.

Indicate Medicare/ Community Medicaid services in this block. For the **Medicare/Third Party Payor** Block, use the following code: **code 23 for Community Medicaid**.

1. Funding Source: Enter the payment code 23, for Community Medicaid, which will pay for the recommended medication service.

2. Service Category: Enter the appropriate code to indicate the service category recommended to meet the need. Be sure that the service category selected is reimbursable under the program/funding source.

For Medication Services, the service category is #42 – Psychiatric Medication Services. You may also select service category #9 or 11, depending on whether the person needs venipuncture and whether it is a RN or LPN, by the hourly rate.

3. Reason Code/Need met: List the reasons for service. New reason codes have been added for these programs.

For Medication Services, the reason code is #30 – Monitor, administer, and/or prefill of psychiatric medications. Also select #31 - Venipuncture if the person requires venipuncture for medication monitoring.

OUTCOME (page 1 of 1):

Section T: ASSESSMENT TYPE/VERSION: Complete the boxes according to the MED form instructions. For program eligibility “T-3” select #27

Section Z: COMMUNITY ELIGIBILITY: Program funding source is #23 - Community Medicaid, Provider is the HH agency name, eligibility start date is date of assessment, reassess date is the end of the current medical eligibility time period.

SIGNATURE: Complete assessment date, assessment version, sign name of person who determined medical eligibility and date signed.

Section 96.02- 4E Venipuncture Only Services

An individual meets the medical eligibility requirements for services under this section if the following are met:

The individual requires only venipuncture services on a regular basis, as ordered by a physician.

AND

A physician must sign and certify a statement that the recipient’s medical condition prevents the safe use of outpatient services and is contraindicated (defined in 96.01-18) for specific reasons. The reasons must be listed and the likelihood of such a bad result must be probable or definite as opposed to possible or rarely. Reasons may include lack of services within a twenty (20) mile radius of the recipient’s residence. Medicaid covers transportation to all Medicaid covered services;

therefore lack of transportation does not qualify as an exemption.

The following sections of the MED tool must be filled out for Venipuncture Services:

BACKGROUND INFORMATION (page 1 of 1):

SECTION HEADER (needs to be filled out on each page)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

All of page 1 must be completed. Be sure to complete the homebound status in Box 20.

CLINICAL DETAIL (page 1 of 5):

Section B. Professional Nursing/Special Treatments and Therapies

1.e - Venipuncture by RN- Code here when service provided by either RN or LPN.

CLINICAL DETAIL (page 3 of 5) MEDICATIONS & DIAGNOSIS:

Section F. MEDICATIONS LIST: If venipuncture is needed to monitor blood levels for a specific medication, this medication section must be completed to document the medication being monitored by venipuncture.

ELIGIBILITY DETERMINATION (page 2 of 4):

Section R12: VENIPUNCTURE ONLY SERVICES: Complete the box by answering the questions and scoring appropriately.

COMMUNITY OPTIONS_ - CAREPLAN SUMMARY (page 1 of 1):

Box 6: Medicare/3rd party payors: recipients with a Community Medicaid card may receive these services if determined medically eligible.

Indicate Medicare/ Community Medicaid services in this block. For the **Medicare/Third Party Payor** Block, use the following code: **code 23 for Community Medicaid.**

1. Funding Source: Enter the payment code 23, for Community Medicaid, which will pay for the recommended venipuncture service.

2. Service Category: Enter the appropriate code to indicate the service category recommended to meet the need. Be sure that the service category selected is reimbursable under the program/funding source.

For Venipuncture Only Services, the service category is either #9 or 11, depending on whether it is a RN or LPN by the hourly rate.

3. Reason Code/Need met: List the reasons for service. New reason codes have been added for these programs.

For Venipuncture Only Services, the reason code is #31 – Venipuncture

OUTCOME (page 1 of 1):

Section T: ASSESSMENT TYPE/VERSION: Complete the boxes according to the MED form instructions. For program eligibility “T-3” select #28

Section Z: COMMUNITY ELIGIBILITY: Program funding source is #23 - Community Medicaid, Provider is the HH agency name, eligibility start date is date of assessment, reassess date is the end of the current medical eligibility time period.

SIGNATURE: Complete assessment date, assessment version, sign name of person who determined medical eligibility and date signed.