Nursing Facility Level of Care Supplemental Form

Instructions

This form should be completed by a clinical evaluator for all MassHealth applicants or members seeking a clinical evaluation to access the Family Assistance (FA) Long Term Services and Supports (LTSS) Pathway. This form must be completed by a registered nurse evaluator (RN). It should be filled out completely and all required supporting clinical documents should be attached.

The minimum supplemental clinical documentation required from each evaluator is described in the following provider bulletins:

- Acute Inpatient Hospital Bulletin 204
- Psychiatric Inpatient Hospital Bulletin 28
- Nursing Facilities Bulletin 193
- Chronic Disease and Rehabilitation Inpatient Hospital Bulletin 104

When this form and the accompanying clinical documentation are completed, the clinical evaluator must submit all information to Disability Evaluation Services (DES). Information should be submitted to DES via fax at (774) 455-8155 or secure email at desdcleaders@umassmed.edu. In collaboration with EOHHS, DES will review and evaluate whether a member meets nursing facility level of care.

Applicant/Member information

Last Name

First Name

MassHealth ID Number *(if applicable)*

Date of Birth *(MM/DD/YYYY)*

Date of member's clinical evaluation

Evaluator information:

Last Name

First Name

Clinical evaluation

In accordance with the clinical eligibility criteria set forth in 130 CMR 456.000: Long Term Care Services, in order to meet nursing facility level of care, a member must:

- require one skilled service listed in 130 CMR 456.409(A) daily, or
- have a medical or mental condition requiring a combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C).

When completing the sections below, indicate the member's clinical needs during the time period that they would receive LTSS services via the Family Assistance LTSS Pathway. For members discharging from a hospital nursing facility, or CDRH, this implies that the evaluation should anticipate a member's clinical needs upon discharge.

Please note in the below sections that the term PCP refers to primary care provider and may include any of the following: a physician, a physician assistant, or a nurse practitioner operating within the scope of their licensure and supervision requirements, as applicable.

1) **Section 1: Skilled services (130 CMR 456.409(A)): Skilled services must be performed by or under the supervision of a registered nurse or therapist.**

Please check the boxes below for the skilled services required by the member on a DAILY basis:

☐ (1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding

☐ (2) nasogastric tube, gastrostomy, or jejunostomy feeding

☐ (3) nasopharyngeal aspiration and tracheostomy care; however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services

☐ (4) treatment and/or application of dressings when the physician or PCP has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions)

☐ (5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema)

☐ (6) skilled nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure)

☐ (7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety

☐ (8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter. A urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled nursing care. However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection)

☐ (9) gait evaluation and training administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting.

☐ (10) certain range-of-motion exercises may constitute skilled physical therapy only if part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record)

☐ (11) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications

☐ (12) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician or PCP and be designed to achieve specific goals within a given time frame.

☐ (13) None of the above

2) Section 2: Assistance with Activities of Daily Living (ADLs) (130 CMR 456.409(B))

Please check the boxes below for services providing assistance with ADLs required by the member:

☐ (1) bathing when the member requires either direct care or attendance or constant supervision during the entire activity

☐ (2) dressing when the member requires either direct care or attendance or constant supervision during the entire activity

☐ (3) toileting, incontinent bladder or bowel, when the member is incontinent of bladder or bowel function day and night, or requires scheduled assistance or routine catheter or colostomy care

☐ (4) transfers when the member must be assisted or lifted to another position

☐ (5) mobility/ambulation when the member must be physically steadied, assisted, or guided in ambulation, or be unable to propel a wheelchair alone or appropriately and requires the assistance of another person;

☐ (6) eating when the member requires constant intervention, individual supervision, or direct physical assistance

☐ (7) None of the above

3) Section 3: Nursing Services (130 CMR 456.409(C)): Nursing services, including any of the following procedures performed at least three times a week, may be counted in the determination of medical eligibility.

Please check the boxes below for the nursing services required by the member AT LEAST THREE TIMES PER WEEK:

☐ (1) any physician- or PCP ordered skilled service specified in 130 CMR 456.409(A)

☐ (2) positioning while in bed or a chair as part of the written care plan

☐ (3) measurement of intake or output based on medical necessity

☐ (4) administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions

☐ (5) staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff

one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental health professional

☐ (6) physician-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals)

☐ (7) physician- or PCP-ordered nursing observation and/or vital signs monitoring, specifically related to the written care plan and the need for medical or nursing intervention

☐ (8) treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician or PCP orders, or routine changing of dressings that require nursing care and monitoring

☐ (9) None of the above

4) Section 4: Narrative summary of clinical needs

Please provide a short narrative summary explaining the member's current situation and clinical needs. This information should be used to explain and/or provide additional information on the clinical needs documented in Sections 1-3 above. This section should also be used to clarify areas of clinical need that are not easily captured in the MDS-HC.

Relevant information to describe here is included but not limited to member history; underlying cause of clinical needs; recent changes in member's status; and/or explanation of the member's needs for skilled nursing observation, management, or evaluation.

Example narrative summary: *Patient admitted to hospital with unstable blood sugar. Member is unable to independently manage daily insulin administration and diabetes mellitus (DM) monitoring and will require assistance with DM management and daily insulin administration in order to safely discharge.*

Note: if further clinical documentation is required beyond this narrative summary and the supplemental clinical documentation, please submit to DES along with this form and the supplemental clinical documentation (e.g., if list of medications or diagnoses exceeds entries on MDS-HC).

Narrative summary

5) Section 5: Clinical re-evaluation

Please indicate when the clinical needs of the members should be re-evaluated. Please base this recommendation on when you expect the member's condition and corresponding LTSS needs to change and/or improve.

Member should be re-evaluated in:

☐ 1 year – *indicate this option if a member's clinical condition is likely to change within a year*

☐ 3 years – *indicate this option if a member's clinical condition is <u>not</u> likely to change within a year*

☐ N/A – *Does not meet clinical eligibility*

6) Section 6: Hospitalization

Individuals who are **newly** accessing the Family Assistance LTSS pathway must meet a hospitalization requirement. This includes members who are currently in a hospital, SNF, or CDRH**.**

For these members, please complete the information below for the member's **most recent** hospitalization:

Name of inpatient hospital: _____

Hospital inpatient admission date: _____

Discharge date: _____

(if member is currently hospitalized at the time of this assessment, write "currently hospitalized" in this field)

If a member is not **newly** accessing the pathway (i.e., is already in the community accessing LTSS services), the hospitalization requirement is waived. For these members, please check the box below.

☐ Member resides in the community– *hospitalization requirement is waived for these members who are currently accessing the pathway and residing in the community*

7) Section 7: All required supporting clinical documents in Sections 1-6 should be included/attached. The clinical evaluator may also include/attach any other supporting documentation.

Please check the boxes below to confirm that each of the documents below have been included in your communications to Disability Evaluation Services (DES):

a. ☐ Supplemental clinical documentation from a clinical evaluator:
    i. ☐ MDS-HC
    ii. ☐ MDS 3.0
    iii. ☐ Clinical eligibility notice issued by local ASAP
    iv. ☐ Eligibility notice issued by Managed Care Entity
    v. ☐ Admission Determination Notice issued by OCA
b. ☐ Nursing Facility Level of Care Supplemental Form
c. ☐ Other relevant clinical documentation

Please describe: _____

_____

_____

8) Section 8: Signature

…… ……

Signature of clinical evaluator Date (MM/DD/YYYY)