New Mexico Human Services Department – Medical Assistance Division

Long Term Care Medical Assessment

PLEASE REMEMBER THIS INFORMATION IS CONFIDENTIAL

A. General Patient Information

1. Assessment Type (check one) ☐ Initial ☐ Annual ☐ Change ☐ Reconsider

2. Patient Name (First, Middle Initial, Last)	3. Medicaid No. or SSN	4. Date of Birth	5. Age	6. Gender ☐ Female ☐ Male
7. Service Type (check one) ☐ Nursing Facility ☐ Waiver ☐ PACE ☐ PCO	8. Patient Mailing Address (address, city, state and zip code)		9. Patient Telephone Contact #	
10. Authorized Representative Name (First, Last)	11. Representative Mailing Address (address, city, state and zip code)		12. Representative Telephone Contact #	

B. General Facility or Agency Information

1. Facility/Agency Name		2. Mailing Address (address, city, state and zip code)	3. Medicaid Provider #	
4. NPI	5. Taxonomy	6. Contact Name (First, Last)	7. Telephone #	8. Fax #

C. Nursing Facility Admissions Information

1. Type ☐ New ☐ Re-Admission ☐ Continued Stay ☐ Transfer	2. Admit Date	3. Source ☐ Hospital ☐ ICF ☐ Home ☐ SNF ☐ Other:	4. Late/Retro ☐ Yes ☐ No	5.Medicaid Eligibility ☐ Active ☐ Pending	6.PASRR Screen ☐ Yes ☐ No

D. Medical Assessment - Physician, Nurse Practitioner or Physician Assistant

1. Diagnosis/Problems (one per line)

If hospitalized since last certification, please enter reason

a.
b.
c.
d.

2. Medication List up to four most important medications, Method of Administration (MOA) and Frequency

	Medication Name	MOA	Frequency
a.			
b.			
c.			
d.			

3. Nursing Services Related to Diagnosis (check up to six)

	Frequency		Frequency
☐ Sterile Dressing	____	☐ Maint. Resp. Therapy	____
☐ Spec. Skin Care	____	☐ Rehab Resp. Therapy	____
☐ Suctioning	____	☐ Maint. Speech Therapy	____
☐ IV	____	☐ Rehab Speech Therapy	____
☐ Tube Feeding	____	☐ Occupational Therapy	____
☐ Oxygen	____	☐ Retrain Bowel/Bladder	____
☐ Irrigations	____	☐ Injections	____
☐ Intake & Output	____	☐ Behavior Observations	____
☐ Decubitus Care	____	☐ Isolation	____
☐ Tracheotomy Care	____	☐ Special Catheter	____
☐ Medication Regulation	____	☐ V/S Evaluation	____
☐ Maint. Physical Therapy	____	☐ CBG	____
☐ Rehab Physical Therapy	____	☐ Special Ostomy Care	____

4. Daily Activities

	1 Independent	2 Needs Help	3 Need Total Assist	✓ If Bedridden
a. Ambulation	☐	☐	☐	☐
b. Bowel Function	☐	☐	☐	☐
c. Transfer	☐	☐	☐	☐
d. Personal Hygiene	☐	☐	☐	☐
e. Eating	☐	☐	☐	☐
f. Bladder Function	☐	☐	☐	☐
g. Control safety	☐	☐	☐	☐
h. Sensory Capabilities	1 None	2 Impairment	3 Total Loss	✓ If Prosthesis
1. Speech	☐	☐	☐	☐
2. Hearing	☐	☐	☐	☐
3. Sight	☐	☐	☐	☐
i. Communication	1 No Problem ☐	2 Non-Verbal ☐	3 Does Not ☐	✓ Lang Barrier ☐
j. Mental	1 Clear ☐	2 Sometimes Disoriented ☐	3 Mostly Disoriented ☐	
k. Behavior	1 Appropriate ☐	2 Inappropriate & Passive ☐	3 Inappropriate & Aggressive ☐	
l. Sociability	1 Freely ☐	2 Occasional ☐	3 Avoids Others ☐	
m. Planned Activities	1 Attends Most ☐	2 Attends Few ☐	3 Never Attends ☐	
n. Diet	1 Regular ☐	2 Modified ☐	3 Therapeutic ☐	4 Formula ☐

5. Physician's Statement

a. Checkmark any attachments below:

☐ Signed Order
☐ History & Physical (See Instructions)
☐ PASRR Screen (Admissions Only)
☐ Progress Notes

b. Patient Status: ☐ 1 Improving ☐ 2 Stable ☐ 3 Unstable ☐ 4 Deteriorating ☐ 5 Critical ☐ 6 Terminal

c. Discharge Planning — If institutionalized, can the patient be discharged to a lower level of care or alternative placement? ☐ Yes ☐ No

d. Medical Record Signature Attestation Statement - *I attest that these medical records and recommendations accurately reflect my treatment and diagnosis for this patient.*

e. LOC Recommendation ☐ Low NF ☐ High NF	f. Physician's Name (Print – First, Last)	g. Physician's Signature (original or electronic)	h. Date
i. Physician's Physical Address (address, city, state and zip code)		j. Physician's Telephone #	k. Physician's Fax #

E. TPA Utilization Review Agent Section Only - Approval subject to eligibility and regulations in effect at time service is rendered.

1. TPA/UR Reviewer Signature (First, Last)	2. Review Date	3.Qualifying ADLs ☐ Dressing ☐ Bath/Hyg./Groom ☐ Mobility ☐ Eating ☐ Toileting ☐ Transfers ☐ Meal Prep ☐ Medications	4. Review Status ☐ Approved ☐ Denied
5. Level of Care ☐ HNF ☐ LNF	6. Service Type ☐ NF ☐ PACE ☐ PCO ☐ Waiver	7. LOC Authorization #	8. LOC Authorization Span Start: End:
9. Discharge Status ☐ Hosp ☐ ICF ☐ Home ☐ LAMA ☐ SNF ☐ INST ☐ HHA ☐ DIED	10. Facility Discharged to (Name)		11. Discharge Date
12. Comments:			

DISTRIBUTION: 1 – TPA; 2 – ISD COUNTY OFFICE; 3 – FACILITY or AGENCY; and 4 – FISCAL AGENT or MCO

Instructions for Form – Medical Assistance Division (MAD) 379
Long Term Care Medical Assessment

PURPOSE: The Long Term Care Medical Assessment form (MAD 379 or "Assessment") is used in the Medicaid program to assess and issue prior approvals (PA) for Nursing Facility (NF) Level of Care (LOC). Medical providers (physician, nurse practitioner or physician assistant) record a patient's medical diagnosis, medications, nursing services and functional levels for daily activities. The medical provider attests that the medical records and recommendation for a HNF (high) or LNF (low) LOC are accurate. Supplemental medical documentation may be required to support information on the MAD 379.

The completed MAD 379 and any supplemental documentation are evaluated by a Third Party Assessor (TPA) to determine if the patient meets the State's criteria for NF LOC. When a patient meets the State's NF LOC and financial eligibility for Medicaid, they may be eligible to receive Medicaid for a nursing facility stay, certain Home and Community-Based Services (HCBS or "Waiver") or Personal Care Option (PCO) services for adults. The MAD 379 is also used to indicate the approved LOC date span. The MAD 379 form may be obtained upon request from the TPA.

INSTRUCTIONS:

A - General Patient Information: This section must contain complete patient identifying and contact information. In box 1, "Assessment Type," check "initial" if this is the first NF LOC assessment. If the patient has a current NF LOC and is due for an annual reassessment, check "Annual." If the physician is submitting an updated assessment because the patient's condition has changed to a different LOC, check, "Change." All changes in LOC require a new MAD 379 that must be submitted within thirty (30) calendar days of the change to a different LOC. If the LOC request was denied and the physician is submitting new information to be considered, check "Reconsider."

B – General Facility or Agency Information: This section must contain complete facility or agency identifying and contact information. In box 3, enter the facility/agency *Medicaid* provider number. In box 4, enter the facility/agency 10-digit National Provider Identifier (NPI) number (no spaces or tabs). In box 5, enter the facility 9-digit taxonomy numbers (no spaces or tabs). In boxes 6, 7 and 8 enter the current contact information for the person at the facility/agency who can provide additional information.

C – Nursing Facility Admissions Information: This section must contain complete NF admissions information. When the patient goes off Medicare co-pay to straight Medicaid, the NF must submit an Initial Assessment form within thirty (30) calendar days from the date of admission to the NF which begins the TPA prior approval review process. In box 1, enter the Type of admission. For first-time placement in the NF, check "New." A "Continued Stay" review request must be received by the TPA prior to expiration of the current LOC date span. A "Re-Admission" review request is required when the patient has left the NF and then returns, after three (3) midnights, to a different LOC. A "Transfer" review request is required when a patient is transferring to another NF. The receiving NF must notify the TPA by telephone that a transfer to their NF is to occur. In box 2, insert the date of admission to the NF. In box 3, check the admission source. Note: "SNF" is a skilled nursing facility and "ICF" is an institutional care facility. In box 4, check yes if your request for an LOC is late and you are requesting a retrospective LOC authorization. In box 5, check the current status of the patient's Medicaid eligibility. In box 6, indicate whether a Pre-Admission Screening and Resident Review (PASRR) was completed. Federal law requires NFs to perform a PASRR that screens for mental illness, mental retardation and related conditions.

D – Medical Assessment: This section must contain a patient's medical diagnosis, medications, nursing services (including frequency of assistance needed), functional ability for daily activities, and the medical provider's attestation and recommendation for HNF or LNF LOC.

In box 5 a, check all documents submitted with the Assessment. Generally, appropriate documentation includes the following:
1) Valid physician, nurse practitioner or physician assistant orders for Medicaid LOC.
2) Resident's Level I PASRR Screen (for NF admissions only);
3) A current History and Physical (H&P) completed within twelve (12) months of the assessment date; and
4) Progress notes for acute changes in condition.

E – TPA/Utilization Review Agency Section Only

ROUTING: For new LOC determinations for patients not enrolled in Medicaid managed care, the TPA will give a blank MAD 379 to the patient for routing to their physician's office for completion. After completion, the physician's office must fax or mail the completed MAD 379 to the TPA. For information about the TPA, visit the HSD website at http://www.hsd.state.nm.us/mad/PUtilReview.html.

For patients enrolled in Medicaid managed care, the Managed Care Organization (MCO) will give a blank MAD 379 to the patient or the patient's physician's office for completion. After completion, the physician's office must fax or mail the completed MAD 379 to the MCO. For information about the MCOs, visit the HSD website at http://www.hsd.state.nm.us/mad/CCoLTSMCOs.html.

If the MAD 379 or supplemental medical documentation is incomplete, the TPA will issue a request for information (RFI) to the provider. If the TPA determines that the patient does not meet NF LOC, the TPA will mail the referring parties a denial letter with the reason for denial as determined by the physician consultant. Providers who are dissatisfied with the TPA's medical necessity decision(s) may request reconsideration (see 8.350.2 NMAC). Patients who disagree with the NF LOC denial can request a Fair Hearing within (90) calendar days of the date of the notice of action (see section 8.352.2 NMAC, Recipient Hearings.)

The TPA must fax and mail copies of the completed MAD 379, inclusive of the UR decision to the appropriate Income Support Division (ISD) office, NF or Agency, and the Medicaid Fiscal Agent or MCO, as appropriate.

FORM RETENTION: Permanent.