Ascend Management Innovations LLC

North Dakota Level of Care and Continued Stay Review Determination Form

To be maintained in medical record. Transfer copy with the resident.

Requested Screen Type

☐ Nursing Facility ☐ Swingbed ☐ CMFN ☐ PACE ☐ MFP Provisional ☐ MFP Final ☐ Tech. Dependent Medicaid Waiver
☐ HCBS Medicaid Waiver ☐ MSP Personal Care ☐ HCBS Medicaid Waiver & MSP Personal Care (*check only if receiving both*)
☐ HCBS/SPED ↓18 ☐ MSP Personal Care & HCBS/SPED ↓18 (*check only if receiving both*) ☐ Children's Hospice

Expected length of stay: ☐ Short Term ☐ Long Term Requested Start Date: _____
Status Change: ☐ Yes ☐ No

Demographics

First/Middle Name: _____ Last Name: _____ Social Security Number: _____
Address: _____ Payment Source: _____
City: _____ State: _____ Zip: _____ Medicaid #: _____
County: _____ Phone: _____ Date of Birth: _____
Gender: ☐ Male ☐ Female Race: _____ Marital Status: _____

Does the individual have a legal guardian? ☐ Yes ☐ No
Guardian First Name: _____ Last Name: _____
Address: _____ Phone : _____
City: _____ State: _____ Zip: _____ Alternate #: _____

Attending Physician First Name: _____ Last Name: _____
Address: _____ Phone : _____
City: _____ State: _____ Zip: _____ Fax #: _____

For NF/SB Screens Only:

☐ Requesting Retrospective Review

Prior Living Situation: ☐ NF ☐ Basic Care ☐ Hospital ☐ Other (Specify: _____)
Current Location: _____ Admission Date: _____
Contact Person: _____ Phone: _____ Fax: _____
Address: _____ City, State, Zip: _____

Receiving Facility: _____ Admission Date: _____
Contact Person: _____ Phone: _____ Fax: _____
Address: _____ City, State, Zip: _____

For MFP Screens Only:

Transition Coordinator Agency: _____

In determining level of care, the individual must require or meet a minimum of one of the criteria listed in *Section A* or two criteria included in *Section B* or criteria in *Section C* or all the criteria in *Section D*.

To assist in determining appropriate criteria for level of care, document all known current and relevant historical medical diagnoses. These do not necessarily need to be the diagnoses for which the individual is seeking services. _____

Section A

1. ☐ Nursing Facility stay is, or is anticipated to be, temporary for receipt of Medicare Part A benefits. Nursing facility stay may be based on this criterion for no more than fourteen (14) days beyond termination of Medicare Part A benefits. Approval under this item will not exceed 30 days. If placement is expected to exceed 30 days, indicate other criteria that apply to the individual in order to be considered for a longer term approval.

2. ☐ The individual is in a comatose state.
   a. Date of Onset: _____
   b. Cause of Coma: _____

3. ☐ The individual requires use of a ventilator for at least six (6) hours per day, seven (7) days per week.
   a. Describe the diagnosis/condition associated with ventilator use: _____
   b. Is there a ventilator weaning schedule? ☐ No ☐ Yes If yes, describe the schedule: _____

4. ☐ The individual has respiratory problems that require regular treatment, observation, or monitoring that can only be provided by or under the direction of a registered nurse (or in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30 (b), a licensed practical nurse) and s/he is incapable of self-care. For individuals being served in the community, these services may be provided by a family member or other support person who has been trained by a nurse or higher-credentialed professional.
   a. Describe the individual's respiratory problem(s): _____
   b. Describe the type(s) of treatment or monitoring needed: _____
   c. Describe the frequency of treatment or monitoring (e.g., constantly, hourly, daily, etc): _____
   d. Describe who will provide the treatment or monitoring: _____
   e. Explain why the individual is not able to self-manage the respiratory problem(s). Describe any cognitive and/or physical limitations. _____

5. ☐ The individual requires constant help at least 60% of the time with at least two (2) of the following Activities of Daily Living (ADLs). Constant help is required if the individual requires a caregiver's continual presence or help, without which the activity would not be completed. This criterion does not apply to individuals who need intermittent assistance.
   - ☐ Toileting (e.g., use of toileting equipment, cleansing, adjustment of clothing)
   - ☐ Eating (e.g., physical assistance with feeding or constant cues/prompting; does not include set-up or meal preparation such as cutting up food)
   - ☐ Transferring (e.g., movement from surface to surface, such as bed to chair or chair to wheelchair)
   - ☐ Locomotion (e.g., movement from place to place, such as room to room)

   a. For each ADL checked above, describe the assistance needed, including frequency of assistance: _____
   b. Explain why the individual is not able to self-manage these ADLs. Describe any cognitive and/or physical limitations. _____

6. ☐ The individual requires aspiration for maintenance of a clear airway. This criterion applies to deep suctioning.
   a. Describe the diagnosis/condition that requires suctioning: _____
   b. Provide the date of initiation of suctioning: _____
   c. Describe the frequency of suctioning (e.g., constantly, hourly, daily, etc): _____
   d. Describe how long suctioning is expected to be required (e.g., for the next month, indefinitely, etc): _____
   e. Explain why the individual is not able to self-manage suctioning. Describe any cognitive and/or physical limitations. _____

Client First/Middle Name: ______________________________ Last Name: ____

7. ☐ The individual has dementia, physician diagnosed or supported with corroborative evidence, for at least 6 months, and as a result of that dementia, the individual's condition has deteriorated to the point that a structured, professionally staffed environment is needed to monitor, evaluate, and accommodate the individual's changing needs.
   a. Is there a diagnosis of dementia? ☐ No ☐ Yes If yes, provide date of diagnosis: ______________________________
   b. Detail the individual's deficits related to dementia. Include details about impairments related to memory; use and understanding of language; ability to carry out motor activities; and ability to plan, carry out, and stop complex activities. Identify the source of this information and describe how these impairments have impacted the individual's day-to-day life (such as disruptions to employment, relationships, safety; cueing; wandering; etc). ______________________________

Section B: (If no criteria in Section A are met, an applicant or resident is medically eligible for NF level of care if **<u>at least two</u>** of the following criteria apply):

1. ☐ The individual requires administration of a prescribed: a. injectable medication; b. intravenous medication and solutions on a daily basis; or c. routine oral medications, eye drops or ointments on a daily basis.

   Provide the following information for each medication prescribed:

Medication	Diagnosis	Dosage	Route/Frequency	Date started
				☐ less than 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ greater than 2 years
				☐ less than 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ greater than 2 years
				☐ less than 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ greater than 2 years
				☐ less than 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ greater than 2 years
				☐ less than 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ greater than 2 years
				☐ less than 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ greater than 2 years

   <u>Medication set-up is included in this criterion, and this assistance can be provided by a family member.</u> Explain why the individual is not able to self-administer these medications. Describe any cognitive and/or physical limitations. ______________________________

2. ☐ The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse, (or in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30 (b), a licensed practical nurse). <u>For individuals being served in the community, these services may be provided by a family member or other support person who has been trained by a nurse or higher-credentialed professional.</u>
   a. Identify the individual's unstable medical condition(s): ______________________________
   b. Describe any recent fluctuations in the individual's medical presentation. This may include changes in lab values, vitals, or levels. It may also include increases in frequency of doctor visits. ______________________________
   c. Describe the services needed related to unstable medical condition(s). Include frequency and who will be providing those services. ______________________________
   d. Explain why the individual is not able to self-monitor the condition(s). Describe any cognitive and/or physical limitations: ____

Client First/Middle Name: _____ Last Name: _____

3. ☐ The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments (e.g., gait training, bowel and bladder training, etc) which are provided at least five (5) days per week. Restorative services must add up to at least 5 days per week and must be delivered by a therapist or by restorative aides or assistants under the direction of the therapist. Therapy orders and notes, if available, are required for the review of this criterion in order to support the individual's needs.
   a. Identify restorative services, frequency, and who will provide them: _____
   b. Describe the individual's goals and progress toward those goals: _____
   c. Describe how long these services are expected to be needed (e.g., for the next month, indefinitely, etc): _____

4. ☐ The individual needs administration of feedings by:
   ☐ nasogastric tube ☐ jejunostomy ☐ gastrostomy ☐ parenteral route
   ☐ Other (specify): _____
   a. Describe the diagnosis/condition for which the feeding tube is required: _____
   b. Describe the frequency of tube feedings (e.g., constantly, hourly, daily, etc): _____
   c. Describe how long tube feedings are expected to be needed (e.g., for the next month, indefinitely, etc): _____
   d. Explain why the individual is not able to self-administer tube feedings. Describe any cognitive and/or physical limitations: _____

5. ☐ The individual requires care of:
   ☐ decubitus ulcers ☐ stasis ulcers
   ☐ other widespread skin disorders (specify): _____
   a. Describe the stage, size, severity, and location of the wound or skin disorder: _____
   b. Describe the treatment required, including frequency (e.g., constantly, hourly, daily, etc): _____
   c. Explain why the individual is not able to self-manage care of the skin disorder. Describe any cognitive and/or physical limitations: _____

6. ☐ The individual requires constant help at least 60% of the time with one (1) of the following. Constant help is required if the individual requires a caregiver's continual presence or help, without which the activity would not be completed. This criterion does not apply to individuals who need intermittent assistance.
   ☐ Toileting (e.g., use of toileting equipment, cleansing, adjustment of clothing)
   ☐ Eating (e.g., physical assistance with feeding or constant cues/prompting; does not include set-up or meal preparation such as cutting up food)
   ☐ Transferring (e.g., movement from surface to surface, such as bed to chair or chair to wheelchair)
   ☐ Locomotion (e.g., movement from place to place, such as room to room)
   a. For each ADL checked above, describe the assistance needed, including frequency of assistance: _____
   b. Explain why the individual is not able to self-manage these ADLs. Describe any cognitive and/or physical limitations. _____

Section C: If no or insufficient criteria in Sections A or B were met, an individual who applies to or resides in a nursing facility designated as a facility for non-geriatric individuals with physical disabilities may demonstrate that nursing facility level of care is medically necessary if:

☐ The individual is determined to have restorative potential. This criterion focuses on the individual's ability to regain lost skills. Maintenance and prevention of deterioration are not included in this criterion. Medical records are required for the review of this criterion in order to support the individual's needs.
   a. Describe the diagnosis/condition which has led to the individual's need to regain lost skills: _____

Client First/Middle Name: _____ Last Name: _____

b. Describe the restorative services required for the individual, including type, frequency, who will provide, and expected duration of those services: _____

c. Describe the individual's goals and progress toward those goals: _____

Section D: If no criteria in Section A, Section B, or Section C are met, the individual who applies for care in a nursing facility may demonstrate that a nursing level of care is medically necessary if **both 1 and 2** are met below.

1. ☐ The individual has an acquired brain injury which includes one of the following:

	Date of Onset:
☐ anoxia	_____
☐ cerebral vascular accident	_____
☐ brain tumor	_____
☐ infection	_____
☐ Traumatic Brain Injury	_____

2. ☐ As a result of the brain injury, the individual requires direct supervision at least eight (8) hours per day, seven (7) days per week. *Supervision* includes oversight, cues, prompts, and physical assistance and may be provided by a family member or other support person. Medical records are required for the review of this criterion in order to support the individual's needs.
Describe the type(s) of supervision needed by the individual, including who provides and frequency: _____

Additional Comments

Use this area for any important information you think was not adequately addressed in the above sections.

Referral Source Information

Person completing form: _____ Facility: _____
Facility Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____

This form may be faxed toll free to Ascend at **877-431-9568 or entered via web at www.pasrr.com.**

Mailed forms may be sent to:
Ascend Management Innovations | Attn: North Dakota Division
227 French Landing Drive, Suite 250 | Nashville, TN 37228
Phone: 877-431-1388 | Fax: 877-431-9568

For assistance with completing this form or accessing WEBSTARS™, call Ascend toll free at 1.877.431.1388 and ask to speak with a ND LTC nurse reviewer.