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Acronyms
Objectives

Long Term Care (LTC) Community Services Waiver Programs workshop covers:

- Medicaid team roles.
- National Provider Identifier/Atypical Provider Identifier (NPI/API) requirements for transaction submission and billing.
- How to create an account for access to the TMHP LTC Online Portal.
- Basic portal features including Form Status Inquiry (FSI) and Current Activity.
- Printing completed assessments and blank assessments.
- How to submit Medical Necessity and Level of Care (MN and LOC) Assessments.
- The Long Term Care Medicaid Information (LTCMI) section field by field.
- Correcting and inactivating assessments.
- How to check the status of an assessment and resolve errors.
- The Texas State University Resource Utilization Group (RUG) training requirements and web address.
- How to report Medicaid Waste, Abuse and Fraud.
- Where to access additional resources.
Medicaid Team

The roles and responsibilities of each of the Medicaid team members.

- **Centers for Medicare & Medicaid Services (CMS)** – Federal Agency that oversees the Medicaid Program on a Federal Level – Guidelines, Rules, and Regulations.

- **Texas Department of Aging and Disability Services (DADS)** administers a comprehensive array of services for persons who are aging and for persons who have Intellectual and Development Disabilities (IDD). Additionally, DADS licenses and regulates providers of these services.

- **Texas Health and Human Services Commission (HHSC)** oversees operations of the entire health and human services system in Texas. It operates the Medicaid acute care program, CHIP, STAR+PLUS, and several other related programs. HHSC’s Office of Eligibility Services (OES) determines eligibility for Medicaid.

- **Health Maintenance Organization (HMO)** is a State-contracted entity that has been given delegated authority to provide acute and long term services and support to enrolled managed care members.

- **Individuals** are those served by the Texas Medicaid Program.

- **Providers** (including HMO’s) are the crucial players in a quality healthcare program. The focus is on providing the best care possible while being reimbursed for allowed services rendered.

- **Texas Medicaid & Healthcare Partnership (TMHP)** is contracted by the State as the claims administrator to process claims for providers under traditional Medicaid and Primary Care Case Management (PCCM). TMHP processes and approves claims for traditional Long Term Care (LTC). TMHP does not pay LTC claims; this is done by the comptroller. Responsibilities also include:
  - Determination of Medical Necessity.
  - Provider education.
  - Timely processing of claims (except for services covered by the STAR+PLUS premium).
  - Representing DADS at fair hearings and supports HHSC at fair hearings in the STAR+PLUS areas.
  - Distribution of yearly manuals, quarterly LTC bulletins, and Remittance and Status (R&S) Reports.
  - Maintaining the TMHP Call Center/Help Desk Monday through Friday, 7:00 a.m.–7:00 p.m., Central Time.
  - Technical assistance on the TexMedConnect online application.

- **Texas State Legislature** allocates budgetary dollars for the Texas Medicaid Program.
NPI/API is a required field for Medical Necessity and Level of Care Assessment submissions on the LTC Online Portal; therefore without an NPI/API, submissions are not allowed and will be rejected.

**Note:** DADS Medically Dependant Children Program (MDCP) Nurses are not required to apply for NPI or API. The API is assigned by DADS.

**To Obtain an NPI**

1. Go to [https://nppes.cms.hhs.gov/NPPES](https://nppes.cms.hhs.gov/NPPES)
2. Click the **National Provider Identifier (NPI)** link to apply for an NPI.
3. Click the **Apply online for an NPI** link; the following page will display:
4. Click the “Begin Application Form” button, located at the bottom of this screen:

5. Complete the NPI application starting with creating a User ID and password as indicated on this screen. Click the “Next” button to continue with the NPI application process. Upon completion, you will receive your NPI.
To Inform DADS of Your NPI/API

1. Go to www.dads.state.tx.us/providers/hipaa/forms.html.

2. Click the Contract NPI/API Association Form (MS Word) link and complete form.

3. Submit a copy of the NPPES NPI notification and a completed DADS Contract NPI/API Association Form by either of the following methods:
   - FAX: 1-512 438-5522
   - Postal Mail Service:
     Department of Aging and Disability Services
     P.O. Box 149030, MC W-517
     Austin, TX 78714-9030

NPI is required on claims and assessment submissions using the following methods:

Electronic

• TexMedConnect
• LTC Online Portal

Paper

• 1290 Claim Form

Note: For more information refer to the DADS information letter found at:
The LTC Online Portal

Providers must use the LTC Online Portal to submit MN and LOC Assessments.

Benefits of Using the LTC Online Portal

- Web-based application.
- 24/7 system availability.
- Application edits verify the validity of data that is entered onto the assessment.
- Provides error messages that must be resolved before submission.
- Form Status Inquiry (FSI) provides a search tool for the status of assessments that have been submitted.
- Current Activity allows providers to view assessment submissions or status changes within the last 14 calendar days.
- Allows providers to submit additional information through the LTC Online Portal.
- TMHP provides LTC Online Portal support by phone at 1-800-626-4117 Monday through Friday, 7:00 a.m.–7:00 p.m., Central Time.

LTC Online Portal Security

Providers must use the LTC Online Portal to submit their MN and LOC Assessments. Third-party vendors cannot submit the MN and LOC on behalf of the provider.

An administrator account is required for portal submissions, and it is strongly recommended to have multiple administrator accounts, in case one administrator is unavailable.

The administrator account is the primary user account for a provider/contract number. This account has the ability to add/remove permissions (access to LTC Online Portal features) for other user accounts on the same provider/contract number. The provider can establish user accounts for each provider/contract number.

A user account can be created by an administrator. User account permissions and limitations are set by the holder of the administrator account. This allows administrators to set the level of access according to employees’ positions.

Note: MDCP nurses obtain LTC Online Portal access directly from HHSC.

If you already have an account, go to www.tmhp.com. Click the Access LTC Online Portal link to login to the LTC Online Portal.

If you do not have an account, follow these steps:

Note: Before you log on, you will need to have:

- Provider number - assigned by DADS when the provider signs the contract to provide Medicaid services.
  For HMOs, the provider number is supplied by HHSC.
• **Vendor number** - assigned by DADS when the provider signs the contract to provide Medicaid services. For HMOs the vendor number/site ID is supplied by HHSC.

• **Vendor password** - provider must call the Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638 to obtain their vendor password. This password is formally known as the MicroECS password. Please note it may take 3-5 business days to receive the password, which is randomly generated by TMHP.

### How to Create an LTC Online Portal Administrator Account

The administrator account is the primary user account. To create an administrator account, follow these steps:

1. Go to [www.tmhp.com](http://www.tmhp.com).
2. Click the **Activate my Account** link.

3. Click the **Create a Provider Administrator Account** link.
4. The following screen will appear. Follow the instructions listed at the top of the screen and click the **Create a provider/vendor administrator account** link at the bottom of the page.

5. Provider Type: Choose **NF/Waiver Programs** from the drop-down box.

   **Note:** The Provider Types listed are the only two choices in the drop-down box that are applicable for this guide.

   - Use **NF/Waiver Programs** to submit MN and LOC Assessments. If you already use TexMedConnect, you are still required to create an NF/Waiver Programs account to submit MN and LOC Assessments.
   - Use **Long Term Care** to access TexMedConnect (for submitting claims, accessing Remittance and Status [R&S] Reports, performing Medicaid Eligibility and Service Authorization Verifications [MESAVs], etc.).

6. Enter your provider number, vendor number, and vendor password.
7. Click the “Next” button.

8. Check the “General Terms and Conditions” box at the bottom of the screen to indicate agreement.

9. Click the **Create Provider Administrator** link to create your User name and password.

   **Note:** The User name and password is used for future logins to your account. Make a copy for your records.

---

**My Account**

**My Account** is used to perform various maintenance activities for your account, such as: setting up user accounts, changing passwords, and other administrative tasks.

To access **My Account**:

1. Go to [www.tmhp.com](http://www.tmhp.com).
2. Click the **My Account** link in the blue navigational bar.

The Help section on this screen has a provider training guide to assist in setting up an account.
Login to the LTC Online Portal

Now that your User name has been created:


2. Click the Access LTC Online Portal link.

3. Enter your User name and password.

4. Click the “OK” button. Upon log in, Form Status Inquiry (FSI) will display by default:
Portal Basics

Blue Navigational Bar Links

All portal features based on your security level will be found in the blue navigational bar located at the top of the portal screen.

Options found in the blue navigational bar may include: Home, Submit Form, Form Status Inquiry, Current Activity, My Drafts, Printable Forms, or Help.

Home

When the blue navigational bar above is displayed, the Home link at the far left will take you to “My Account.” If you are already at the “My Account” page, the Home link will take you back to the www.tmhp.com home page.

Submit Form

This feature allows providers to submit Waiver: Medical Necessity and Level of Care Assessments.
Note: The steps to submit the MN and LOC are covered in the Medical Necessity and Level of Care Assessment Section.

Form Status Inquiry

Form Status Inquiry (FSI) provides a query tool for monitoring the status of assessments that have been submitted. This allows providers to retrieve assessments in order to:

- Access assessments to research and review statuses.
- Provide additional information to an assessment.
- Retrieve assessments to perform a correction or inactivation. (See Corrections and Inactivations sections within this participant guide.)

1. Click the **Form Status Inquiry** link in the blue navigational bar.
2. Type of Form: Choose **Waiver: Medical Necessity and Level of Care Assessment** from the drop-down box.
3. Enter data for all required fields as indicated by the red dots. Narrow results by entering specific criteria in the additional fields: “DLN,” “Last Name,” “First Name,” “SSN,” “Medicaid Number,” “Form Status,” and “From” and “To” Dates.
Note: “From” and “To” Dates are searched against the “TMHP Received Date” (e.g. the date the assessment was successfully submitted).

4. Click the “Search” button.

5. Click the View Detail link of the requested assessment.

Descriptions of the column headings seen above are:

- **View Detail**: The hyperlink used to open the assessment.
- **DLN**: The unique document locator number assigned to each successfully submitted assessment.
- **TMHP Received Date**: The actual date the assessment was successfully submitted on the LTC Online Portal.
- **SSN (AA5a), Medicaid # (AA7), Medicare # (AA5b), First Name and Last Name (AA1)**: Information used to identify individual associated with assessment.
- **Status**: The status of the assessment at the time of search.
- **RUG**: The assigned RUG value.
- **RN Signature Date**: Date Assessment was Completed as identified in field R2b.
- **Purpose Code**:
  - Purpose Code 1: The Utilization Review Assessment.
- **Contract Number**: The nine-digit provider number.
- **Vendor Number**: The four-digit site identification number.
- **Reason for Assessment (AA8a)**:
  - 01: Admission Assessment (Initial)
  - 02: Annual Assessment
  - 03: Significant Change in Status Assessment

**Current Activity**

Providers have the ability to view assessment submissions or status changes within the last 14 calendar days.

1. Click the **Current Activity** link in the blue navigational bar.

2. Click the appropriate vendor number (if applicable).
3. The results will display a summary of all assessment submissions or status changes within the last 14 calendar days.

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Received</th>
<th>SSN</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Name</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/11/2008 1:44:01 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Processed/Complete</td>
</tr>
<tr>
<td>10/13/2008 8:56:43 AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Med ID Check Inactive</td>
</tr>
<tr>
<td>10/21/2008 2:20:25 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Denied</td>
</tr>
<tr>
<td>10/27/2008 2:04:04 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Submitted to manual workflow</td>
</tr>
<tr>
<td>11/19/2008 3:04:18 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Denied</td>
</tr>
<tr>
<td>3/13/2009 3:35:40 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Submitted to manual workflow</td>
</tr>
<tr>
<td>3/16/2009 10:33:19 AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Denied</td>
</tr>
<tr>
<td>3/19/2009 3:13:19 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pending Denial (need more information)</td>
</tr>
<tr>
<td>3/20/2009 2:10:40 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Processed/Complete</td>
</tr>
<tr>
<td>3/20/2009 4:49:50 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pending Denial (need more information)</td>
</tr>
<tr>
<td>3/24/2009 11:52:00 AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Denied</td>
</tr>
</tbody>
</table>

Descriptions of the column headings seen above:

- **Waiver**: The unique document locator number assigned to each successfully submitted assessment.
- **Received**: The actual date the assessment was successfully submitted on the LTC Online Portal.
- **SSN (AA5a), Medicaid (AA7), Medicare (AA5b), First Name and Last Name (AA1)**: Information used to identify individual associated with assessment.
- **Status**: The status of the assessment.

4. Click the **document locator number** (DLN) link of the requested assessment to view in detail.

**My Drafts**

This feature allows the user to access all drafts previously saved under the specific User name that was used to create the original draft.

**Note**: Only the user who created the original draft will be able to access the draft. Other users, including the administrator, will not have access to drafts saved under another’s User name.

To access a saved draft:

1. Click the **My Drafts** link in the blue navigational bar.
2. From here:
   a. Click the **Open** link to open the draft assessment to edit and submit.
   
   or
   
   a. Click the **Remove** link to permanently delete the draft assessment.

   **Note:** *Once a draft has been removed it cannot be retrieved.*

**Printable Forms**

This feature allows the provider to view and/or print blank assessments:

1. Click the **Printable Forms** link in the blue navigational bar.

2. Click the **Waiver** link. A new window and application called Adobe Reader will open displaying the blank assessment in PDF (Portable Document Format).

3. Click the “Print” Icon.
   
   – To print the entire document:
   
   a. Printer: Choose printer name from drop-down box.
   
   b. Print Range: Click the “All” circle.
   
   c. Click the “OK” button.
LTC Community Services Waiver Programs Workshop Participant Guide

To print certain pages instead of the entire document:

a. Printer: Choose printer name from drop-down box.

b. Print Range: Click the “Pages” circle.

c. Enter the pages to print. (example: 1-5 will print all pages 1 through 5; 1,3,7 will print only pages 1, 3 and 7.)

d. Click the “OK” button.

Help

The **Help** link at the far right in the blue navigational bar will display a Help page consisting of links to online guides to be used in conjunction with TMHP’s LTC Online Portal that will assist with questions you may have. Assistance for RNs with completing the Medical Necessity and Level of Care Assessment can be found at the **Medical Necessity and Level of Care Assessment Instructions** link.
Yellow Form Actions Bar

Options found in the yellow Form Actions bar may include: Print, Use as template, Correct this form, Add Note or Inactivate Form. Options will vary depending on your security as well as the assessment status. The yellow Form Actions bar is available when an individual assessment is being viewed in detail.

**Print**

This feature allows the provider to print completed MN and LOC Assessments. Use the “Print” button to print completed assessments.

**Note:** To only print specific sections of the assessment, click the Pages circle and enter the page range for the desired pages only.

**Use as template**

This feature allows a provider to complete a new assessment by using the information in a completed assessment as a template. Various fields will prepopulate; be sure to check for accuracy.

Once you have found the assessment using FSI or Current Activity:

1. Click the “Use as template” button. The data in this assessment will be used to create a new assessment.

2. Enter data into remaining fields not prepopulated.

   **Note:** Fields not prepopulated are: Assessment Reference Date (ARD), Date Assessment was Completed (R2b) and Admission to Medicaid Date (S1b).

3. Click the “Print” button located in the yellow Form Actions bar to print the assessment in progress. (If you want a hard copy for your records).
4. From here:
   a. Click the “Submit Form” button located at the bottom right of the screen, if ready to submit for processing.
   or
   a. Click the “Save as Draft” button located in the yellow Form Actions bar to save an assessment as a draft until ready to submit.

**Correct this form**

This feature allows providers to perform corrections to the MN and LOC Assessment within 14 days of the original submission (e.g. TMHP received date). However, corrections are not allowed if an assessment is set to status “Form Inactivated” or “Invalid/Complete”.

**Note:** The steps to correct an assessment are covered in the Corrections section.

**Add Note**

“Add Note,” located in the yellow Form Actions bar, may be used to add additional Medical Necessity (MN) information not captured upon original submission or if the status is “Pending Denial (need more information).”

To add a note to a submitted assessment:

1. Locate the assessment using the FSI or Current Activity.
2. Click the “Add Note” button, a text box will open.
3. Enter additional information (up to 500 characters) to the text box.
4. Click the “Save” button to save your note or “Cancel” button to erase your note, located under the text box.
Note: If unsure why an assessment is set to status “Pending Denial (need more information)” please call the TMHP Help Desk (1-800-626-4117, Option 2) to speak with a nurse. If “Add Note” is chosen to any assessment set to status “Pending Denial (need more information)” the assessment will be reviewed again for medical necessity. If the nurse is unable to approve the assessment with the additional information provided, the assessment will be sent to the TMHP Medical Director for review and determination of medical necessity.

Inactivate Form

This feature allows providers to inactivate a MN and LOC Assessment. Once inactivated, the assessment will not be available for further processing, but it may be used as template. **Inactivations are not allowed if an assessment is set to status “Corrected.”**

Note: The steps to inactivate an assessment will be covered in the Inactivations section.

Other Basic Information

Required Fields

Within the portal, red dots indicate required fields. Fields without the red dot are optional.
History

An assessment’s history can be found by scrolling down on an open assessment. This history shows the different statuses the assessment has held. The most recent will appear at the bottom.

<table>
<thead>
<tr>
<th>Status</th>
<th>Time</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form Submitted</td>
<td>3/25/2009 2:52:36 PM</td>
<td></td>
</tr>
<tr>
<td>Pending Review</td>
<td>3/25/2009 2:52:37 PM</td>
<td>TNHP: The Form has failed Auto MN Approval</td>
</tr>
<tr>
<td>Approved</td>
<td>3/26/2009 9:09:39 AM</td>
<td></td>
</tr>
<tr>
<td>ID Confirmed</td>
<td>3/26/2009 9:09:49 AM</td>
<td>TNHP: Medicaid ID confirmed for this client</td>
</tr>
<tr>
<td>SBA Request</td>
<td>3/26/2009 9:09:50 AM</td>
<td>TNHP: The request is being processed by DADS. Please allow 2-4 business days for the next status change.</td>
</tr>
</tbody>
</table>

UnLock Form

Upon opening, the assessment becomes automatically locked by the viewer and will remain locked for 20 minutes of no activity or until the viewer clicks the “UnLock Form” button. The “UnLock Form” button will unlock the assessment so that a different user can make changes. If an assessment is locked, others will not be able to make changes or add additional information. You may be asked to unlock an assessment if you are seeking assistance from TMHP or DADS.

To unlock an assessment, click the “UnLock Form” button located at the top right corner of the screen.

Error Messages

If required information is missing or information is invalid, error message(s) will display and you will not be able to move onto the next step until resolved. You may need to scroll up to see this section. You may also click the error message hyperlink to be directed automatically to the field(s) containing the error.

Please fix these errors:

- Type of Form is required

The page will not submit until these are corrected.
Entering Dates

To enter dates, you have the option to click on the calendar icon next to any of the date fields to activate the dynamic calendar. Choose the date desired. Or, you may enter in the date using the mm/dd/yyyy format.

![Date of Birth Calendar](image)

Timeout

The assessment will timeout after 20 minutes of no activity. To prevent this timeout from occurring, complete and submit within 20 minutes or click on a different tab (e.g. Section A) to reset the timer, then return to the previous tab.
Medical Necessity and Level of Care Assessment

MN and LOC Assessments are submitted to determine medical necessity for individuals in the community.

There are three reasons to submit an MN and LOC Assessment:

- **AA8a = 01. Admission Assessment (Initial)**
- **AA8a = 02. Annual Assessment**
- **AA8a = 03. Significant Change in Status Assessment (SCSA), submitted when authorized by the case manager due to changes in the medical condition of the individual.**

**Note:** HMO's complete SCSA but do not submit on the portal. Print and keep in individual's records.

All assessments must be submitted through the LTC Online Portal. If the assessment is submitted successfully, a Document Locator Number (DLN) will be assigned and the following message will be displayed.

If an assessment is not successfully submitted, an error message will appear at the top of the screen, the provider must resolve the error(s) to ensure the assessment will be submitted successfully. The error message will prompt the provider as to how to resolve the error or save to draft for research and correction at a later date. If the provider is unable to resolve the error, they may contact TMHP and choose option one for assistance.

**Note:** The TMHP LTC Online Portal will not accept an MN and LOC assessment with a calculated BC1 RUG. All fields known to cause the BC1 RUG will need to be corrected before the assessment will submit successfully. Details of how to correct a BC1 RUG are located in the “How to Correct BC1 RUG” section.
How to Submit a Medical Necessity and Level of Care Assessment

1. Login to the LTC Online Portal.

2. Click the **Submit Form** link located in the blue navigational bar.

3. Type of Form: Choose **Waiver: Medical Necessity and Level of Care Assessment** from the drop-down box.

4. To prepopulate recipient information in the MN and LOC Assessment, enter one of the following combinations of information:
   - Medicaid/Children with Special Healthcare Needs (CSHCN) ID
   - Social Security Number AND Last Name
   - Social Security Number AND Date of Birth
   - Date of Birth AND Last Name AND First Name

   **Note:** All demographic information (except gender) is prepopulated when one of the afore mentioned data is entered. Refer to the MN and LOC section AA.

5. Click the “Enter Form” Button.
6. Click the tabs (i.e. Section AA, Section A, Section B, etc) and enter the assessment information.
   a. Click the “Submit Form” button to submit the MN and LOC.
   
   or

   b. Click the “Save as Draft” button to save an MN and LOC as a draft to be recalled later.
Overview of the MN and LOC Assessment

The MN and LOC consist of 19 sections:

- Section AA: Identification Information
- Section A: Identification and Background Information
- Section B: Cognitive Patterns
- Section C: Communication/Hearing Patterns
- Section D: Vision Patterns
- Section E: Mood and Behavior Patterns
- Section G: Physical Functioning and Structural Problems
- Section H: Continence in the Last 30 Days
- Section I: Diseases/Diagnoses
- Section J: Health Conditions
- Section K: Oral/Nutritional Status
- Section M: Skin Conditions
- Section N: Activity Pursuit Patterns
- Section O: Medications
- Section P: Special Treatments and Procedures
- Section Q: Discharge Potential and Overall Status
- Section R: Signature/Date Completed
- Section U: Medications
- Section LTCMI

Detailed explanations of the MN and LOC Assessment sections can be found at the following locations:

- Go to [www.tmhp.com/LTC%20Programs/default.aspx](http://www.tmhp.com/LTC%20Programs/default.aspx) and click the Medical Necessity and Level of Care Instructions link found under the Community Waivers Programs heading; or
- Click the Help link in the blue navigational bar and click the Medical Necessity and Level of Care Instructions link.

Blank MN and LOC Assessments can be found at the following locations:

- Go to [www.tmhp.com/LTC%20Programs/default.aspx](http://www.tmhp.com/LTC%20Programs/default.aspx) and click the Medical Necessity and Level of Care Assessment link found under the Community Waivers Programs heading; or
- Click the Printable Forms link in the blue navigational bar and click the Waiver link.

**Note:** For reference only, a blank MN and LOC Assessment is located at the back of this participant guide.
Long Term Care Medicaid Information (LTCMI)
• **S1. Medicaid Information.**
  - S1a. Medicaid Client Indicator.
    - Choose “1” if Medicaid Client.
  - S1b. Admission to Medicaid Date (date of the assessment or the date of the last face to face assessment). Refer to your MN and LOC item by item guide for additional information.
  - S1c. Admitted From.
    1. Home.
    2. Hospital.
    3. Nursing Facility.
    4. State school/Facility.
    5. Other.
    6. Cannot Determine.
  - S1d. Individual Address (Enter street address of individual or Legally Authorized Representative).
  - S1e. City.
  - S1f. State.
  - S1g. Zip Code.
  This address is used to send client letters (i.e. denial letters).

• **S2. Claims Processing Information.**
  - S2a. DADS Vendor/Site ID Number.
  - S2b. Contract/Provider Number.
  - S2c. Service Group.
  - S2d. NPI Number (required field).
    This is where Atypical Provider Identifier (API) would be entered if using an API number. API is “D,” two zeros, then contract number, i.e. MDCP nurses would use an API.
  - S2e. Region.
  - S2f. Purpose Code.
    - S2f Purpose Code 1: Is used for Utilization Review (UR) only. This field is pre-populated and unavailable for data entry.
  
  **Note:** *DADS RN performs the MDCP assessment & DADS UR RN performs the quality assessments (Purpose Code 1). This UR assessment will override the assessment by the provider.*

• **S3. Primary Diagnosis.**
  - S3a. Primary Diagnosis International Classification of Diseases Ninth Revision (ICD-9).
    Enter a valid ICD-9 code for the recipient’s primary diagnosis. Use your best clinical judgment.
  - S3b. Primary Diagnosis ICD-9 Description.
    To populate the ICD-9 description, click the magnifying glass icon.

• **S4. For DADS use only.**
• **S5. Licenses.**
  - S5a. DADS RN Last Name.
  - S5b. DADS RN License#.
  - License number entered is validated against Texas State University RUG training database, and the Board of Nursing (BON) database.
  - S5b1. DADS RN License State.
    **Note:** *S5a-S5b1 are required for Service Group (SG) 18 MDCP.*
  - S5c. HHA (Home Health Agency) RN Last Name.
  - S5d. HHA RN License#.
  - License number entered is validated against Texas State University RUG training database, and the Board of Nursing (BON) database.
  - S5d1. HHA RN License State.
    **Note:** *S5c-S5d1 are required for SG 3 CBA/ICM and SG 17 CWP.*
  - S5e. DADS UR (Utilization Review) RN Last Name.
  - S5f. DADS UR RN License#.
  - License number entered is validated against Texas State University RUG training database, and the Board of Nursing (BON) database.
  - S5f1. DADS UR RN License State.
  - S5g1. Is DADS UR RN Signature on Assessment.
  - S5g. DADS UR RN Signature Date.
    **Note:** *S5e-g are required for utilization reviews.*
  - S5h. PACE RN Last Name.
  - S5i. PACE License#.
  - License number entered is validated against Texas State University RUG training database, and the Board of Nursing (BON) database.
  - S5i1. PACE License State.
    **Note:** *S5h-S5i1 are required for PACE SG 11.*
  - S5j. HMO (Health Maintenance Organization) RN Last Name.
  - S5k. HMO RN License#.
  - License number entered is validated against Texas State University RUG training database, and the Board of Nursing (BON) database.
  - S5k1. HMO RN License State.
    *STAR+PLUS HMO providers will enter HMO RN last name and license number in lieu of DADS RN information.*
  - **Note:** *S5j-S5k1 are required for STAR+PLUS SG 19.*
• **S6. Therapeutic Interventions.**
  - S6a. Tracheostomy Care.
    Required. A non-zero reply is required if assessment field P1aj, Tracheostomy care, is checked.
  - S6b. Ventilator/Respirator (Do not include BIPAP or CPAP time).

• **S7. Physician's Evaluation & Recommendation.**
  - S7a. Certification of supervision.
  - S7b. MD/DO Last Name.
  - S7c. MD/DO License#.
    Validated against the Texas Medical Board (TMB) file. The address on file with the TMB is the address used to send the physician letters (i.e. denial letters).
  - S7c1. MD/DO License State.
  - S7d. MD/DO Military Spec Code#.

• **S8. Comments.**
The comments field allows for up to 500 characters to be added. It is essential that you include signs and symptoms that present an accurate picture of the individual’s condition. The comments section can be used for additional qualifying data that indicates the need for skilled nursing care, such as:
  - Pertinent medical history.
  - Ability to understand medications.
  - Ability to understand changes in condition.
  - Abnormal vital signs.
  - Previous attempts at outpatient management of medical condition.
  - Results of abnormal lab work.
Definition of Medical Necessity (MN) and the MN Determination Process

Definition of Medical Necessity

“Medical Necessity is the determination that a recipient requires the services of licensed nurses in an institutional setting to carry out the physician’s planned regimen for total care. A recipient’s need for custodial care in a 24-hour institutional setting does not constitute a medical need. A group of health care professionals employed or contracted by the Medicaid claims administrator contracted with HHSC makes individual determinations of medical necessity regarding nursing facility care. These health care professionals consist of physicians and registered nurses.” – 40 TAC 19.101 #73

The Differences in Licensed Nurse Needs and Custodial Care

Custodial care is identified as care given by nurses’ aides or lay caregivers that provide safety and/or assistance with activities of daily living such as: bathing, toileting, eating, dressing and ambulation/mobility.

Licensed nurse needs are defined as skills provided by licensed nursing personnel to assess, plan, supervise, and provide treatment on a regular basis. To include, but are not limited to, observation; promotion and maintenance of health; prevention of illness and disability; management of health care during acute and chronic phases of illness; guidance and counseling of individuals and families; and referral to physicians, other health care providers, and community resources when appropriate.

General Qualifications for Medical Necessity Determinations

According to 40 TAC 19.2401, Medical necessity is the prerequisite for participation in the Medicaid (Title XIX) Long Term Care program. This section contains the general qualifications for a medical necessity determination. To verify that medical necessity exists, an individual must meet the conditions described in paragraphs (1) and (2) of this section.

1. The individual must demonstrate a medical condition that:

   (A) is of sufficient seriousness that the individual’s needs exceed the routine care which may be given by an untrained person; and

   (B) requires licensed nurses’ supervision, assessment, planning, and intervention that are available only in an institution.
2. The individual must require medical or nursing services that:

(A) are ordered by the physician;
(B) are dependent upon the individual’s documented medical conditions;
(C) require the skills of a registered or licensed vocational nurse;
(D) are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and
(E) are required on a regular basis.

Note: MN is only one of the criteria that must be met as a prerequisite for LTC Medicaid Waiver programs.

Medical Necessity Determination Process

This flowchart provides a high level overview of the process used for determination of medical necessity.

1. The assessments are reviewed by the TMHP nurse within 3 business days to determine medical necessity.

   TMHP systems automatically review specific criteria on the assessments. If the criteria are appropriately met, the assessment is automatically approved. If not, the provider will see “The Form has failed Auto MN Approval” displayed in the form history. The assessment will then be sent to a nurse for manual MN review. The status will show “Pending Review” on the FSI search results; however, the last message showing in the history will be “The Form has failed Auto MN Approval.”
2. Once reviewed, the assessment is either approved (meeting medical necessity) or set to status of “Pending Denial (need more information)” for up to 21 days. Form Status Inquiry (FSI) or Current Activity will allow the provider to view the status of an assessment during the MN determination process.

3. The provider may supply additional information clarifying nursing/medical needs through the “Add Note” feature on the LTC Online Portal or by calling TMHP and speaking with a TMHP nurse.

4. If the TMHP nurse determines that medical necessity has been met, the assessment is approved.

5. If the TMHP nurse still cannot determine any licensed nursing need, the individual’s assessment is sent to the TMHP physician for a medical necessity determination.

6. If the TMHP physician determines that medical necessity has been met, the assessment is approved.

7. If the medical necessity is denied by the TMHP physician, notification of denied medical necessity is sent to the individual and the physician of record via mail. The provider will have accesses to the status of the assessment via the Form Status Inquiry/Current Activity on the LTC Online Portal.

8. The attending physician may respond within 14 calendar days of receipt of the denial letter by faxing or calling TMHP with additional medical information (40 TAC 19.2407). Or, a licensed nurse familiar with the individual may provide additional information by calling and speaking with a TMHP nurse.

9. If the TMHP physician determines that medical necessity has been met, the assessment is approved.

10. If the TMHP physician determines that medical necessity has not been met, the denial will be upheld.

11. The individual may initiate the appeal process when notified by a DADS worker via the form 2065C, that MN has been denied by TMHP physician. If a hearing is requested, additional information may be submitted at any time by the provider or by the individual’s physician either via a phone call to the TMHP nurses or via fax.

12. If the provider does not provide additional information clarifying nursing/medical needs within the 21 days of “Pending Denial (need more information)” status, the assessment is sent to the TMHP physician for review, and steps 7-11 will apply.

**Note:** At any point, providers can check the status of the assessments and the MN determination for the assessment by utilizing the LTC Online Portal features of FSI or Current Activity.

### Request for Fair Hearing

Waiver individuals may request to appeal a denial through their DADS Caseworker. The DADS Caseworker initiates the appeal process by notifying the Fair Hearing Officer. The Caseworker completes a 4800 form and sends the hearing request form to the Fair Hearing Officer. The Fair Hearing Officer will then contact the TMHP Fair Hearing Department with the hearing date and time. The provider will be notified of the hearing date and time by the Fair Hearing Officer.

**Note:** The process for waiver managed care members and the HMOs to follow is included in the Uniform Managed Care Contract.
Assessment Status

Providers can monitor the status of their MN and LOC Assessment by utilizing FSI or Current Activity on the LTC Online Portal. Once a specific assessment is selected, the status can be located at the bottom of the assessment in the History section, the top of the page, and within the FSI or Current Activity results. The following are statuses that a provider may see, and their definition:

- **Appealed:** The assessment was previously denied and the individual or their representative has requested a fair hearing.
- **Approved:** Medical necessity has been determined and approved.
- **Corrected:** This assessment has been corrected by the submitting provider. There will be a new DLN located in the History indicating the replacement DLN for the corrected assessment. No further actions allowed on assessment with a status of corrected.
- **Denied:** The assessment has been reviewed by the TMHP doctor who has determined that the information did not support medical necessity.
- **Escalated Needs Review:** The assessment has been escalated to a DADS worker for review.
- **Form Inactivated:** This assessment has been inactivated by the submitting provider. No further action may be allowed on this assessment.
- **ID Invalid:** Medicaid ID validation failed. Contact the Medicaid Eligibility Worker to verify the individual’s name, Social Security Number, and Medicaid ID. A new assessment with the correct information will need to be submitted.
- **Invalid/Complete:** Per DADS, this assessment has been deemed invalid. The reason can be found in the History. A new assessment will need to be submitted with the correct information.
- **Med ID Check Inactive:** Medicaid ID validation attempted nightly for up to 6 months and failed or the request was cancelled. Provider may restart the assessment once the reason for failed validation has been resolved by the Medicaid Eligibility Worker by clicking the “Restart Form” button.
- **Medicaid ID Pending:** Medicaid ID validation is pending. Validation attempts occur nightly until deemed valid, invalid or until 6 months has expired, whichever comes first. Contact the Medicaid Eligibility Worker to verify the individual’s name, Social Security Number, and Medicaid ID.
- **Out of State RN License Invalid:** TMHP has done a manual check on the out of state license and has found it to be invalid. This often happens because the provider entered the wrong state. If the information on the assessment is incorrect, the provider can submit a correction within 14 days of submission to fix the erroneous information.
- **Overturrened Doctor Review:** Assessment was denied medical necessity, and the provider has supplied additional information for review. The assessment is pending “TMHP Doctor review for MN determination.
- **Pending Denial (need more information):** The assessment has been reviewed for medical necessity by a TMHP RN. The information did not support approving medical necessity. The provider has up to 21 days to supply additional information for consideration either via phone or the “Add Note” feature.
- **Pending More Info:** DADS is waiting for more information from the provider. Information required may be found within the assessment History.
• **Pending Review:** Assessment is waiting for TMHP RN to manually review it for medical necessity.

• **Pending RN License Verification:** RN License number is pending manual verification by TMHP from the Texas Board of Nursing or the licensing state from which the compact license was issued.

• **Processed/Complete:** Assessment has been processed and complete. Please check MESAV.

• **Provider Action Required:** Assessment must be reviewed by the provider due to the assessment being Rejected by SAS. Refer to the assessment History for the specific error message. The error message must be resolved before further processing of assessment will occur.

• **SAS Request Pending:** Assessment has passed all TMHP validations and will be sent from TMHP to DADS for SAS processing. Please allow 2-4 days for the next status change.

• **Submitted to manual workflow:** Assessment has been submitted to DADS due to the assessment being Rejected by SAS. Refer the assessment History for additional information.
Provider Workflow

Provider Workflow allows providers to independently manage their assessments when errors in the Medicaid system processing occur. The assessments going into the Provider Workflow are those situations where the provider is required to take action for resolution of the problem. The Provider Workflow allows providers to directly manage their rejections which occurred during the Medicaid processing. The benefit to the provider is shorter time in resolution since providers can resolve their own errors.

In Summary, Provider Workflow is:

- Assessment has not been successfully processed.
- Error occurred during system processing.
- Rejection error message can be found within the assessment history.
- Ownership for resolution belongs to the provider.
- Assessment status is “Provider Action Required.”

It is the responsibility of the provider to monitor and manage the Provider Workflow. Assessments are placed in the Provider Workflow as a result of the Medicaid system processing discovering an error while attempting to process the assessment. System processing errors are found within the history of the assessment and the status is set to “Provider Action Required.” Once an assessment is set to status “Provider Action Required,” the assessment will require provider action before processing on that particular assessment continues.

If a system error occurs, the error will display in the history of the assessment. The assessment is set to status “Provider Action Required.”
Finding Assessments with “Provider Action Required” Status

To find the items in your Provider Workflow (i.e., those items with system processing errors to be resolved by the provider):

1. Click the **Form Status Inquiry** link in the blue navigational bar.
2. Choose Type of Form: **Waiver: Medical Necessity and Level of Care Assessment** from the drop-down box.
3. Enter the “From Date” and “To Date” range Form Status: Choose **Provider Action Required** from the drop-down box.

4. Click the “Search” button located on the bottom right of the screen.
5. Those Waiver: Medical Necessity and Level of Care Assessments with a status of “Provider Action Required” will display.

Note: for confidentiality purposes, the assessment details (i.e., Medicaid #, etc.) have been hidden in this document.

6. Click the View Detail link to open the assessment.

7. Scroll to the bottom of the page to view History.
8. Find “Provider Action Required” status on the far left. It should be the very last line in the history.

9. Find the rejection message in the white line just below “Provider Action Required.”

10. Perform the necessary research to resolve the error.

11. Depending on the provider research, providers have one of three options to move the assessment out of the provider workflow.

   - **Correct this form.** “Correct this form” allows provider to submit a correction within 14 days of the original submission date. The original assessment with a status of “Provider Action Required” will be given a status of “Corrected” and will have a parent relationship DLN to the new/child assessment. The new assessment replaces the original assessment.

   The following fields are not correctable:

   - **AA1** Individual Name (does not allow changes to last name).
   - **AA5a** Social Security No.
   - **AA5b** Medicare or RR Retirement Claim No.
   - **AA7** Medicaid Recipient No.
   - **AA8** Reasons for Assessment.
   - **B1** Comatose (because of conditional fields).
   - **J2** Pain Symptoms (because of conditional fields).
   - **K5** Nutritional Approaches (because of conditional fields).
   - **N1** Time Awake (because of conditional fields).
   - **R2b** Date Assessment Completed.
   - **S5i** DADS UR RN Signature Date.
   - **S2a** Vendor.
   - **S2b** Contract.
   - **S2c** Service Group.
   - **S2d** NPI.
Inactivate Form. “Inactivate Form” will inactivate the assessment. The status of the assessment will then change to “Form Inactivated.” An example of when this “Inactivate Form” button would be used is when the provider research indicates the assessment being submitted is a duplicate.

Resubmit Form. “Resubmit Form” will set assessment to status “SAS Request Pending.” The assessment will process during the nightly system processing. Check the status of the assessment the next day to determine if the assessment processed successfully. Status will be “Processed/Complete” if successfully processed.

12. If the provider chooses “Correct this form” the provider will complete a new assessment. The original assessment that was in the status of “Provider Action Required” will be set to status “Corrected” with a parent relationship DLN to the new/child assessment. The new assessment replaces the original assessment.

If the provider chooses “Inactivate Form” the provider will receive the following confirmation window.

Click the “OK” button to Inactivate, and the assessment will set to status “Form Inactivated.” Click the “Cancel” button to cancel the Inactivation request keeping the assessment status as “Provider Action Required.”
If the provider chooses “Resubmit Form” the following screen will appear allowing the provider to add any comments.

There is an option to select “2-System” or “1-ProviderFacing.”

- **2-System**: will allow comments entered by the provider to be seen only by internal state staff. The comments will not be seen by the provider.

- **1-ProviderFacing**: will allow comments entered to be seen by both state staff and the provider.

In either case, the comments will be seen in the History section of the assessment.

The provider may choose to enter comments. Entering comments is optional.

Click the “Cancel” button to cancel the request, keeping the assessment in the status of “Provider Action Required.”

or

Click the “Change Status” button to move the assessment out of the “Provider Action Required.”

13. Once one of the actions has been completed by—“Correct this form,” “Inactivate Form,” or “Resubmit Form”—the status of the assessment will no longer be “Provider Action Required.”
## Provider Workflow Rejection Messages

Below are the rejection messages providers will receive as a result of an error occurring during the nightly system processing. The messages are in order of message number.

The table contains 4 columns:

1. **Message Number.** This is the specific error message that will be displayed in the portal.
2. **System Message.** Further clarification of the portal error message including basic example of the situation.
3. **Associated with Reason for Assessment.** What assessment type can result in the error.
   - AA8a = 01. Admission Assessment (Initial)
   - AA8a = 02. Annual Assessment
   - AA8a = 03. Significant Change in Status Assessment
4. **Suggested Action.** Most likely the Workflow Action Button to be used.

<table>
<thead>
<tr>
<th>Reject Message Description</th>
<th>System Message (Displayed in History)</th>
<th>Associated with Reason for Assessment</th>
<th>Suggested Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS-0001</td>
<td>CS-0001: The request cannot be processed because an existing Initial assessment (01) has already been processed. Please contact the case manager or submit an Annual assessment (02), or SCSA (03) as appropriate.</td>
<td>AA8a = 01</td>
<td>The request cannot be processed because an existing Initial assessment has already been processed. Please contact the case manager or inactivate the Initial assessment and submit an Annual Assessment (or SCSA) as appropriate.</td>
</tr>
<tr>
<td>CS-0003</td>
<td>CS-0003: The request cannot be processed because the Annual assessment (02) is being submitted more than 90 days prior to the Service Plan end date. Please resubmit the assessment at the appropriate time.</td>
<td>AA8a = 02</td>
<td>Inactivate Form and submit annual when within the 90 days.</td>
</tr>
<tr>
<td>CS-0004</td>
<td>CS-0004: The request cannot be processed because the Annual assessment (02) has been submitted more than 132 days after the end of the last Service Plan. Please submit an Initial assessment (01).</td>
<td>AA8a = 02</td>
<td>The request cannot be processed because the Annual assessment has been submitted more than 132 days after the end of the last Service Plan. Inactivate Annual Assessment and submit an Initial Assessment.</td>
</tr>
<tr>
<td>CS-0005</td>
<td>CS-0005: The request cannot be processed because a previous Service Plan cannot be found. Please submit an Initial assessment (01).</td>
<td>AA8a = 02</td>
<td>The request cannot be processed because a previous Service Plan cannot be found. Please submit an Initial assessment.</td>
</tr>
<tr>
<td>CS-0006</td>
<td>CS-0006: The request cannot be processed because an Initial assessment (01) for the individual cannot be found. Please verify data entry or contact the case manager.</td>
<td>AA8a = 03</td>
<td>The request cannot be processed because an Initial assessment for the individual cannot be found. Please verify data entry or contact the case manager.</td>
</tr>
<tr>
<td>Reject Message Description</td>
<td>System Message (Displayed in History)</td>
<td>Associated with Reason for Assessment</td>
<td>Suggested Action</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>CS-0011</td>
<td>CS-0011: The request cannot be processed because there is not an open Service Plan for the individual. Please verify data entry or contact the case manager.</td>
<td>AA8a = 03</td>
<td>Inactivate Form.</td>
</tr>
<tr>
<td>CS-0012</td>
<td>CS-0012: The request cannot be processed because the SCSA assessment (03) is being submitted more than 30 days after the Service Plan end date.</td>
<td>AA8a = 03</td>
<td>Inactivate Form.</td>
</tr>
</tbody>
</table>
Corrections

If incorrect data on the MN and LOC Assessment is submitted, the provider can submit a correction within 14 calendar days of original submission. However, not all fields are correctable (see previous list in the provider workflow section).

Examples of incorrect data are:

- Individual listed as a male but is actually a female.
- Individual’s diagnosis indicates diabetes but the individual actually has hypoglycemia.

If corrections to the MN and LOC Assessment are needed, providers must access the assessment utilizing Form Status Inquiry (FSI) or Current Activity.

When to correct assessment: data submitted is incorrect.

Who may submit the correction: It does not have to be the original submitter, but it has to be from the same vendor/contract.

Note: The DADS MDCP and UR RN acts as a provider when submitting the MN and LOC.

How to Submit a Correction

1. Click the Form Status Inquiry link in the blue navigational bar.

2. Type of Form: Choose Waiver: Medical Necessity and Level of Care Assessment from the drop-down box.

3. Enter data for all required fields as indicated by the red dots. Narrow results by entering specific criteria in the additional fields: “DLN,” “Last Name,” “First Name,” “SSN,” “Medicaid Number,” “Form Status,” and “From” and “To” Dates.

4. Click the “Search” button.
5. Click the **View Detail** link of the requested assessment.

6. Click the “Correct this form” button.

7. Complete only the fields needing correction.

8. Click the “Submit Form” button.

9. The original assessment (parent) is set to status “Corrected” and the new assessment (child) DLN is assigned, creating the parent/child DLN relationship. The new child assessment replaces the parent assessment.
Inactivations

MN and LOC Assessments may be inactivated. Assessments may need to be inactivated when fields cannot be corrected as needed. (i.e. Medicaid #, Individual Name). MN and LOC Assessments can be inactivated through the LTC Online Portal by first retrieving the assessment using FSI or Current Activity.

When to inactivate: An assessment needs to stop processing in the workflow, or if an assessment needs to be cancelled, if already processed to completion.

Who may inactivate: It does not have to be the original submitter, but it has to be inactivated from the same vendor/contract.

Inactivation may be performed based on the vendor/contract who submitted the assessment originally. None of the DADS or TMHP teams (Community Services [CS] Workers, CS Team Leads, TMHP Operations) may submit an inactivation on an MN and LOC Assessment. There are no time limitations to perform an inactivation. Assessments are set to status “Form Inactivated.” Once the assessment is inactivated, however, it can be used as a template, and a new assessment must be submitted.

1. Login to the LTC Online Portal.
2. Find your document using FSI or Current Activity.
3. Click the View Detail link.
4. Click the “Inactivate Form” button.
5. When the dialog box stating “Are you sure you want to Inactivate this form?” appears:
   a. Click the “OK” button to Inactivate the assessment.
   or
   a. Click the “Cancel” button if you do not want to Inactivate the assessment.

Note: Once inactivated, assessments cannot be reactivated and assessment will be set to status “Form Inactivated.”
How to Correct BC1 RUG

A BC1 RUG is due to an out of range value on an assessment and will result in the lowest default RUG. The TMHP LTC Online Portal will not accept an MN and LOC assessment with a calculated BC1 RUG. All fields known to cause the BC1 RUG will need to be corrected before the assessment will submit successfully.

To resolve your BC1, validate the following assessment fields fall within the look-back period of seven (7) days:

- **E. Behavioral Symptoms.**
  - E.4a – e (A) Behavioral Frequency.
  - E.4a – e (B) Behavioral Alterability.

- **J. Health Conditions.**
  - J.1a – p Indicators.

- **O. Medications.**
  - 0.3 Injections.
  - 0.4 Days Received the Following Medication.

- **P. Special Treatments and Procedures.**
  - P.1b (A) Therapies Days.
  - P.1b (B) Therapies Minutes.
  - P.3 Nursing Rehabilitation/Restorative Care.

The following assessment fields should fall within the new look-back period of 14 days:

- **P. Special Treatments and Procedures.**
  - P.7 Physician Visits.
  - P.8 Physician Orders.
RUG Training Requirements

Resource Utilization Group (RUG) training is intended for long-term care nurses, and providers associated with the Department of Aging and Disability Services Community Programs. RUG training is designed to provide providers the requirements for completing RUG fields in assessments for Texas Medicaid payment.

Texas State University, in cooperation with the HHSC Office of Inspector General (OIG) has made this training available through the Office of Continuing Education’s online course program.

To register for the RUG training, or for more information visit: www.txstate.edu/continuinged/programs/Online-Programs/RUG-Training.html

RUG training is valid for 2 years then it must be renewed by completing the online RUG training via Texas State University.

Resource Utilization Groups (RUG) training is required for Registered Nurses (RNs) who sign assessments as complete. The RN license number listed on section S5 of the LTCMI is validated for completion of RUG training. An error will occur if the license number does not pass validation. The assessment will not be considered successfully submitted until all errors are resolved.

Texas State University RUG training can take 2-7 working days (M-F, 8-5) to process and report completions of RUG training to TMHP, depending on current volume of enrollments and completions.

RUG Worksheet and Definitions

To view the RUG worksheet and definition for each RUG classification, go to http://tinyurl.com/TMHP-LTC-RUG-Worksheet
Reminders

- Utilize Form Status Inquiry and Current Activity. These features will keep you informed of the status of your assessments.
- Print and sign assessment prior to submission.
- Provide pertinent information in the Comments section.
- Submit additional information, within 21 days, through the LTC Online Portal or call when your assessment is in status "Pending Denial (need more information)."
- All RN and MD/DO licenses will be validated against the Texas Board license files for successful submission.
- Use the TMHP website at [www.tmhp.com/LTC%20Programs](http://www.tmhp.com/LTC%20Programs) for recent updates and new information.
What is Medicaid Fraud?

"An intentional deceit or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law."

How to Report Waste, Abuse and Fraud

Reports may be made through the following website: [https://oig.hhsc.state.tx.us](https://oig.hhsc.state.tx.us). This website also gives instructions on how to submit a report, as well as, how to submit additional documentation that cannot be transmitted over the Internet. The website also provides information on the types of waste, abuse and fraud to report to OIG (Office of Inspector General).

If you are not sure if an action is waste, abuse or fraud of the Medicaid Program, report it to OIG and let the investigators decide. If you are uncomfortable about submitting a report online, there is a phone number for Client Fraud and Abuse reporting: 1-800-436-6184.

HIPAA Guidelines and Provider Responsibilities

Providers must comply with the Health Insurance Portability and Accountability Act (HIPAA). It is YOUR responsibility to comply with HIPAA, to seek legal representation when needed, and to consult the manuals/speak to representatives when you have questions.
Contact Information

TMHP Call Center/Help Desk

Telephone ........................................................................................................1-800-727-5436/1-800-626-4117
Fax ......................................................................................................................1-512-514-4223
General Inquiries: Press 1
Medical Necessity: Press 2
Technical Support: Press 3
Audio Message Paper Submitters: Press 4

Medicaid Hotline ...............................................................................................1-800-252-8263
RUG Training Information .................................................................................1-512-245-7118
EDI Help Desk ....................................................................................................1-888-863-3638
LTC Helpdesk .....................................................................................................1-800-626-4117
TMHP General Customer Service .......................................................................1-800-925-9126
Medicaid Fraud ..................................................................................................1-800-436-6184

Community Based Alternatives Program Contacts
Completing the MN and LOC Assessment: Contact your Regional Nurse

Consolidated Waiver Program Contacts
Completing the MN and LOC Assessment: ......................................................512-438-3444

Medically Dependent Children Program Contacts
Completing the MN and LOC Assessment: Contact the RLS State Office Nurse: 512-438-5837

Integrated Care Management
Business Rules Questions: ..............................................................512-438-3169 or email Heather.Powell@hhsc.state.tx.us

PACE Program Contacts
Completing the MN and LOC Assessment: ......................................................512-438-2489

STAR+PLUS Program Contacts
Business Rule Questions: ..............................................................Contact David.Johnson@hhsc.state.tx.us
Questions regarding Medical Necessity Determinations: Contact the Texas Medicaid & Healthcare Partnership at 1-800-727-5436
DADS Regional Nurse Contact Information

<table>
<thead>
<tr>
<th>Region</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1/10</td>
<td>1-915-834-7566</td>
</tr>
<tr>
<td>Region 2/9</td>
<td>1-325-795-5725</td>
</tr>
<tr>
<td>Region 3</td>
<td>1-940-320-8249</td>
</tr>
<tr>
<td>Region 4/5</td>
<td>1-903-737-0226</td>
</tr>
<tr>
<td>Region 6</td>
<td>1-713-967-7678</td>
</tr>
<tr>
<td>Region 7</td>
<td>1-254-750-9268</td>
</tr>
<tr>
<td>Region 8</td>
<td>1-210-438-6216</td>
</tr>
<tr>
<td>Region 11</td>
<td>1-956-983-7645</td>
</tr>
</tbody>
</table>

Informational Websites

<table>
<thead>
<tr>
<th>Website</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare and Medicaid Services</td>
<td><a href="http://www.cms.gov">www.cms.gov</a></td>
</tr>
<tr>
<td>Community Care Programs</td>
<td><a href="http://www.dads.state.tx.us/providers/index.cfm">www.dads.state.tx.us/providers/index.cfm</a></td>
</tr>
<tr>
<td>Consumer Rights and Services (includes information about how to make a complaint)</td>
<td><a href="http://www.dads.state.tx.us/news_info/report_problems.html">www.dads.state.tx.us/news_info/report_problems.html</a></td>
</tr>
<tr>
<td>DADS Services</td>
<td><a href="http://www.dads.state.tx.us/services">www.dads.state.tx.us/services</a></td>
</tr>
<tr>
<td>Health and Human Services Commission</td>
<td><a href="http://www.hhsc.state.tx.us">www.hhsc.state.tx.us</a></td>
</tr>
<tr>
<td>HHSC Regions</td>
<td><a href="http://www.hhsc.state.tx.us/aboutHHS/HHS_Regions.shtml">www.hhsc.state.tx.us/aboutHHS/HHS_Regions.shtml</a></td>
</tr>
<tr>
<td>Long Term Care Policies</td>
<td><a href="http://www.dads.state.tx.us/providers/index.cfm">www.dads.state.tx.us/providers/index.cfm</a></td>
</tr>
<tr>
<td>Long Term Care Updates and Banner Messages</td>
<td><a href="http://www.tmhp.com/LTC%20Programs">www.tmhp.com/LTC%20Programs</a></td>
</tr>
<tr>
<td>Medicaid Fraud</td>
<td><a href="https://oig.hhsc.state.tx.us/">https://oig.hhsc.state.tx.us/</a></td>
</tr>
<tr>
<td>Medicaid Nursing Facility Program</td>
<td><a href="http://www.dads.state.tx.us/providers/NF/index.cfm">www.dads.state.tx.us/providers/NF/index.cfm</a></td>
</tr>
<tr>
<td>Medical Necessity and Level of Care Assessment and Instructions</td>
<td><a href="http://www.tmhp.com/LTC%20Programs">www.tmhp.com/LTC%20Programs</a></td>
</tr>
<tr>
<td>RUG Cost Ceiling Information</td>
<td><a href="http://www.hhsc.state.tx.us/medicaid/programs/rad/lcsvs.html">www.hhsc.state.tx.us/medicaid/programs/rad/lcsvs.html</a></td>
</tr>
<tr>
<td>RUG Training</td>
<td><a href="http://www.txstate.edu/continuinged/programs/Online-Programs/RUG-Training.html">www.txstate.edu/continuinged/programs/Online-Programs/RUG-Training.html</a></td>
</tr>
<tr>
<td>RUG Worksheet and Definitions</td>
<td><a href="http://tinyurl.com/TMHP-LTC-RUG-Worksheet">http://tinyurl.com/TMHP-LTC-RUG-Worksheet</a></td>
</tr>
<tr>
<td>Texas Administration Code</td>
<td><a href="http://www.sos.state.tx.us/tac/index.html">www.sos.state.tx.us/tac/index.html</a></td>
</tr>
<tr>
<td>Texas Department of Aging and Disability Services</td>
<td><a href="http://www.dads.state.tx.us">www.dads.state.tx.us</a></td>
</tr>
<tr>
<td>Texas Department of State Health Services</td>
<td><a href="http://www.dshs.state.tx.us">www.dshs.state.tx.us</a></td>
</tr>
<tr>
<td>Texas Medicaid &amp; Healthcare Partnership (TMHP)</td>
<td><a href="http://www.tmhp.com">www.tmhp.com</a></td>
</tr>
<tr>
<td>TMHP Long Term Care Division</td>
<td><a href="http://www.tmhp.com/LTC%20Programs">www.tmhp.com/LTC%20Programs</a></td>
</tr>
<tr>
<td>Vendor Drug Program</td>
<td><a href="http://www.hhsc.state.tx.us/hcf/vdp/vdpstart.html">www.hhsc.state.tx.us/hcf/vdp/vdpstart.html</a></td>
</tr>
</tbody>
</table>
For CBA and CWP Providers

The due dates for the annual reassessment packets submitted by Home and Community Support Services (HCSS) agencies to the case managers are listed below.

**Note:** *TMHP does not support any assessments other than the Medical Necessity and Level of Care Assessment.*

The table below lists the reassessment due dates based on the date of the IPC expiration:

<table>
<thead>
<tr>
<th>IPC Expiration Date (&quot;To&quot; date on IPC)</th>
<th>Reassessment Packet Due to Case Manager Between</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 31</td>
<td>November 1 - November 30</td>
</tr>
<tr>
<td>February 28 or 29</td>
<td>December 1 - December 31</td>
</tr>
<tr>
<td>March 31</td>
<td>January 1 - January 31</td>
</tr>
<tr>
<td>April 30</td>
<td>February 1 - February 28 or 29</td>
</tr>
<tr>
<td>May 31</td>
<td>March 1 - March 31</td>
</tr>
<tr>
<td>June 30</td>
<td>April 1 - April 30</td>
</tr>
<tr>
<td>July 31</td>
<td>May 1 - May 31</td>
</tr>
<tr>
<td>August 31</td>
<td>June 1 - June 30</td>
</tr>
<tr>
<td>September 30</td>
<td>July 1 - July 31</td>
</tr>
<tr>
<td>October 31</td>
<td>August 1 - August 31</td>
</tr>
<tr>
<td>November 30</td>
<td>September 1 - September 30</td>
</tr>
<tr>
<td>December 31</td>
<td>October 1 - October 31</td>
</tr>
</tbody>
</table>
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>API</td>
<td>Atypical Provider Identifier</td>
</tr>
<tr>
<td>ARD</td>
<td>Assessment Reference Date</td>
</tr>
<tr>
<td>BON</td>
<td>Board of Nursing</td>
</tr>
<tr>
<td>CA</td>
<td>Current Activity</td>
</tr>
<tr>
<td>CBA</td>
<td>Community Based Alternative</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CS</td>
<td>Community Services</td>
</tr>
<tr>
<td>CSHCN ID</td>
<td>Children with Special Health Care Needs Identification number</td>
</tr>
<tr>
<td>CWP</td>
<td>Consolidated Waiver Program</td>
</tr>
<tr>
<td>DADS</td>
<td>Department of Aging and Disability Services</td>
</tr>
<tr>
<td>DD</td>
<td>Developmental Disabilities</td>
</tr>
<tr>
<td>DLN</td>
<td>Document Locator Number</td>
</tr>
<tr>
<td>DO</td>
<td>Doctor of Osteopathy</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<tr>
<td>FSI</td>
<td>Form Status Inquiry</td>
</tr>
<tr>
<td>HCSS</td>
<td>Home and Community Support Services</td>
</tr>
<tr>
<td>HHA</td>
<td>Home Health Agency</td>
</tr>
<tr>
<td>HHSC</td>
<td>Health and Human Services Commission</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>ICD-9</td>
<td>International Classification of Diseases Ninth Revision</td>
</tr>
<tr>
<td>ICM</td>
<td>Integrated Care Management</td>
</tr>
<tr>
<td>ID</td>
<td>Intellectual Disabilities</td>
</tr>
<tr>
<td>IDD</td>
<td>Intellectual and Developmental Disabilities</td>
</tr>
<tr>
<td>IPC</td>
<td>Individual Plan of Care</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>LTCM</td>
<td>Long Term Care Medicaid Information</td>
</tr>
<tr>
<td>MD</td>
<td>Medical Doctor</td>
</tr>
<tr>
<td>MDCP</td>
<td>Medically Dependent Children's Program</td>
</tr>
<tr>
<td>MESAV</td>
<td>Medicaid Eligibility and Service Authorization Verification</td>
</tr>
<tr>
<td>MN</td>
<td>Medical Necessity</td>
</tr>
<tr>
<td>MN and LOC</td>
<td>Medical Necessity and Level of Care</td>
</tr>
<tr>
<td>NF</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>NPPES</td>
<td>National Plan and Provider Enumeration System</td>
</tr>
<tr>
<td>OES</td>
<td>Office of Eligibility Services</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of the Inspector General</td>
</tr>
<tr>
<td>PACE</td>
<td>Program of the All-inclusive Care for the Elderly</td>
</tr>
<tr>
<td>PCCM</td>
<td>Primary Care Case Management</td>
</tr>
<tr>
<td>PDF</td>
<td>Portable Document Format</td>
</tr>
<tr>
<td>PRN</td>
<td>Pro re nata (Latin) — as needed</td>
</tr>
<tr>
<td>RA</td>
<td>Route of Administration</td>
</tr>
<tr>
<td>R &amp; S</td>
<td>Remittance and Status</td>
</tr>
<tr>
<td>R2b</td>
<td>Date Assessment was completed</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>RUG</td>
<td>Resource Utilization Group</td>
</tr>
<tr>
<td>SAS</td>
<td>Service Authorization System</td>
</tr>
<tr>
<td>SCSA</td>
<td>Significant Change in Status Assessment</td>
</tr>
<tr>
<td>SG</td>
<td>Service Group</td>
</tr>
<tr>
<td>SSN</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>State of Texas Access Reform (STAR) + PLUS</td>
</tr>
<tr>
<td>TAC</td>
<td>Texas Administrative Code</td>
</tr>
<tr>
<td>TBN</td>
<td>Texas Board of Nursing</td>
</tr>
<tr>
<td>THCA</td>
<td>Texas Health Care Association</td>
</tr>
<tr>
<td>TMB</td>
<td>Texas Medical Board</td>
</tr>
<tr>
<td>TMHP</td>
<td>Texas Medicaid and Healthcare Partnership</td>
</tr>
<tr>
<td>UR</td>
<td>Utilization Review</td>
</tr>
</tbody>
</table>
## SECTION AA. IDENTIFICATION INFORMATION

1. **INDIVIDUAL NAME**
   - a. (First)
   - b. (Middle initial)
   - c. (Last)
   - d. (Jr/Sr)

2. **GENDER**
   - 1. Male
   - 2. Female

3. **BIRTHDATE**
   - Month
   - Day
   - Year

4. **RACE/ETHNICITY**
   - 1. American Indian/Alaskan Native
   - 2. Asian/Pacific Islander
   - 3. Black, not of Hispanic origin
   - 4. Hispanic
   - 5. White, not of Hispanic origin

5. **SOCIAL SECURITY**
   - **a. Social Security Number**
   - **b. Medicare number (or comparable railroad insurance number)**

6. **MEDICAID NO.**
   - (*"+" if pending, "N" if not a Medicaid recipient)

7. **REASONS FOR ASSESSMENT**
   - Primary reason for assessment
   - Annual assessment
   - Significant change in status assessment
**SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION**

<table>
<thead>
<tr>
<th>A1. INDIVIDUAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. (First)</td>
<td></td>
</tr>
<tr>
<td>b. (Middle Initial)</td>
<td></td>
</tr>
<tr>
<td>c. (Last)</td>
<td></td>
</tr>
<tr>
<td>d. (Uni/Br)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A2. ROOM NUMBER</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A3. ASSESSMENT REFERENCE DATE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last day of observation period</td>
<td>Month</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A4. DATE OF MOST RECENT HOSPITALIZATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of most recent hospitalization discharge in last 90 days</td>
<td>Month</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SECTION B. COGNITIVE PATTERNS**

<table>
<thead>
<tr>
<th>B1. COMATOSE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Recall of what was learned or known)</td>
<td></td>
</tr>
<tr>
<td>0. No</td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B2. MEMORY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Short-term memory OK—seems appears to recall</td>
<td></td>
</tr>
<tr>
<td>0. Memory OK</td>
<td>1. Memory problem</td>
</tr>
<tr>
<td>b. Long-term memory OK—seems appears to recall long past events</td>
<td></td>
</tr>
<tr>
<td>0. Memory OK</td>
<td>1. Memory problem</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B3. MEMORY/RECALL ABILITY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that individual was normally able to recall during last 30 days</td>
<td></td>
</tr>
<tr>
<td>a. Location of own room</td>
<td></td>
</tr>
<tr>
<td>b. Current season</td>
<td></td>
</tr>
<tr>
<td>c. That he/she is in own home room</td>
<td></td>
</tr>
<tr>
<td>d. Caregiver/family names</td>
<td>NONE OF ABOVE are recalled</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Made decisions regarding tasks of daily life</td>
<td></td>
</tr>
<tr>
<td>0. INDEPENDENT—decisions consistent/reasonable</td>
<td></td>
</tr>
<tr>
<td>1. MODIFIED INDEPENDENCE—some difficulty in new situations only</td>
<td></td>
</tr>
<tr>
<td>2. MODERATELY IMPAIRED—decisions poor; cues/supervision required</td>
<td></td>
</tr>
<tr>
<td>3. SEVERELY IMPAIRED—never made decisions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[Check for behavior in the last 30 days.] (Note: Accurate assessment requires conversations with caregiver/family who have direct knowledge of individual’s behavior over this time.)</td>
<td></td>
</tr>
<tr>
<td>a. Behavior not present</td>
<td></td>
</tr>
<tr>
<td>b. Behavior present, not of recent onset</td>
<td></td>
</tr>
<tr>
<td>c. Behavior present, over last 30 days appears different from individual's usual functioning (e.g., new onset or worsening)</td>
<td></td>
</tr>
<tr>
<td>d. Periods of altered perception or awareness of surroundings (e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses right and day)</td>
<td></td>
</tr>
<tr>
<td>e. Episodes of disorganized speech (e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)</td>
<td></td>
</tr>
<tr>
<td>f. Periods of restlessness (e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)</td>
<td></td>
</tr>
<tr>
<td>g. Periods of lethargy (e.g., sluggishness; staring into space; difficult to arouse; little body movement)</td>
<td></td>
</tr>
<tr>
<td>h. Mental function varies over the course of the day (e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION C. COMMUNICATION/HEARING PATTERNS**

<table>
<thead>
<tr>
<th>C1. HEARING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(With hearing appliance, if used)</td>
<td></td>
</tr>
<tr>
<td>0. HEARS ADEQUATELY—normal talk, TV, phone</td>
<td></td>
</tr>
<tr>
<td>1. MINIMAL DIFFICULTY when not in quiet setting</td>
<td></td>
</tr>
<tr>
<td>2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly</td>
<td></td>
</tr>
<tr>
<td>3. HIGHLY IMPAIRED—absence of useful hearing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C2. COMMUNICATION DEVICES/TECHNIQUES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that apply (during last 30 days)</td>
<td></td>
</tr>
<tr>
<td>a. Hearing aid, present and used</td>
<td></td>
</tr>
<tr>
<td>b. Hearing aid, present and not used regularly</td>
<td></td>
</tr>
<tr>
<td>c. Other receptive comm. techniques used (e.g., lip reading)</td>
<td>NONE OF ABOVE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C3. MODES OF EXPRESSION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all used by individual to make needs known</td>
<td></td>
</tr>
<tr>
<td>a. Speech</td>
<td></td>
</tr>
<tr>
<td>b. Writing messages to express or clarify needs</td>
<td></td>
</tr>
<tr>
<td>American sign language or Braille</td>
<td></td>
</tr>
<tr>
<td>c. Signs/Gestures/Sounds</td>
<td></td>
</tr>
<tr>
<td>d. Communication Board</td>
<td></td>
</tr>
<tr>
<td>Voice Modulator</td>
<td>h. NONE OF ABOVE</td>
</tr>
</tbody>
</table>

**SECTION D. VISION PATTERNS**

<table>
<thead>
<tr>
<th>D1. VISION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Ability to see in adequate light and with glasses if used)</td>
<td></td>
</tr>
<tr>
<td>0. ADEQUATE—sees fine detail, including regular print in newspapers/books</td>
<td></td>
</tr>
<tr>
<td>1. IMPAIRED—sees large print, but not regular print in newspapers/books</td>
<td></td>
</tr>
<tr>
<td>2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify street signs</td>
<td></td>
</tr>
<tr>
<td>3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D2. VISUAL LIMITATIONS/DIFFICULTIES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SIDE VISION PROBLEMS—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)</td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>NONE OF ABOVE</td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>Glasses, contact lenses, magnifying glass</td>
</tr>
<tr>
<td>f.</td>
<td>No</td>
</tr>
</tbody>
</table>

**SECTION E. MOOD AND BEHAVIOR PATTERNS**

<table>
<thead>
<tr>
<th>E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Code for indicators observed in last 30 days, irrespective of the assumed cause)</td>
<td></td>
</tr>
<tr>
<td>0. Indicator not exhibited in last 30 days</td>
<td></td>
</tr>
<tr>
<td>1. Indicator of this type exhibited daily over 5 days a week</td>
<td></td>
</tr>
<tr>
<td>2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E2. MOOD PERSISTENCE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to “cheer up”, consolidate, or reassure the Individual over last 30 days</td>
<td></td>
</tr>
<tr>
<td>0. No mood</td>
<td>1. Indicators present, easily altered</td>
</tr>
<tr>
<td>2. Indicators present, not easily altered</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E3. CHANGE IN MOOD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual’s mood status has changed as compared to status of 30 days ago (or since last assessment if less than 30 days)</td>
<td></td>
</tr>
<tr>
<td>0. No change</td>
<td>1. Improved</td>
</tr>
<tr>
<td>2. Deteriorated</td>
<td></td>
</tr>
</tbody>
</table>

**SAD APATHETIC, ANXIOUS APPEARANCE**

| I. Sad, pained, worried facial expressions—e.g., furrowed brows |   |
| II. Crying, tearfulness |   |
| III. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking |   |

**LOSS OF INTEREST**

| a. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends |   |
| b. Reduced social interaction |   |
### Section G. Physical Functioning and Structural Problems

#### G1. ADL Self-Performance (Code for individual performance over a 24 hr period during last 30 days—Not including setup)

- **Independent**—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 30 days
- **Supervision**—Oversight, encouragement or cueing provided 3 or more times during last 30 days
- **Limited Assistance**—Individual highly involved in activity, received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times— OR—More help provided only 1 or 2 times during last 30 days
- **Extensive Assistance**—While individual performed part of activity, over last 30-day period, help of following type(s) provided 3 or more times:
  - **Weight-bearing support**—Full staff performance during part (but not all) of last 30 days
- **Total Dependence**—Full staff performance of activity during entire 30 days

#### G2. ADL Support Provided (Code for Most Support Provided over a 24 hr period during last 30 days; code regardless of individual’s self-performance classification)

<table>
<thead>
<tr>
<th>LOCOMOTION IN HOME</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How individual moves to and from locations in his/her home and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BODY PART</th>
<th>RANGE OF MOTION LIMITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td>0. No limitation 0. No loss</td>
</tr>
<tr>
<td>Arm—Including shoulder or elbow</td>
<td></td>
</tr>
<tr>
<td>Foot—Including ankle or toes</td>
<td></td>
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<tr>
<td>Other limitation or loss</td>
<td></td>
</tr>
</tbody>
</table>

### Section H. Continence in Last 30 Days

#### H1. Continence Self-Control Categories (Code for Individual’s Performance OVER A 24 hr period in last 30 days)

- **Continence**—Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]
- **Occasionally Incontinent**—BLADDER, 2 or more times a week but not daily; BOWEL, less than weekly
- **Frequently Incontinent**—BLADDER, tends to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
- **Incontinent**—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

#### G3. Maintain Balance

<table>
<thead>
<tr>
<th>Balance while standing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Maintained position as required</td>
<td></td>
</tr>
<tr>
<td>1. Unsteady, but able to rebalance self without physical support</td>
<td></td>
</tr>
<tr>
<td>2. Partial physical support required; or stands ( sits) but does not follow directions</td>
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</tr>
<tr>
<td>3. Not able to attempt balance without physical help</td>
<td></td>
</tr>
</tbody>
</table>

#### G4. Functional Limitation in Range of Motion (Code for limitations during last 30 days that interfered with daily functions or placed individual at risk of injury)

<table>
<thead>
<tr>
<th>Range of Motion</th>
<th>Voluntary Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No limitation</td>
<td></td>
</tr>
<tr>
<td>1. Limitation on one side</td>
<td></td>
</tr>
<tr>
<td>2. Limitation on both sides</td>
<td></td>
</tr>
<tr>
<td>3. Full loss</td>
<td></td>
</tr>
</tbody>
</table>

#### G6. Modes of Transfer

<table>
<thead>
<tr>
<th><em>Code all that apply during last 30 days</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedfast all or most of time</td>
</tr>
<tr>
<td>Bed rails used for bed mobility or transfer</td>
</tr>
</tbody>
</table>
**SECTION I. DISEASES/DIAGNOSIS**

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

<table>
<thead>
<tr>
<th>Code</th>
<th>Disease/Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Paraplegia</td>
</tr>
<tr>
<td>b.</td>
<td>Parkinson's disease</td>
</tr>
<tr>
<td>c.</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>d.</td>
<td>Quadruplegia</td>
</tr>
<tr>
<td>e.</td>
<td>Hypertension</td>
</tr>
<tr>
<td>f.</td>
<td>Transient ischemic attack (TIA)</td>
</tr>
<tr>
<td>g.</td>
<td>Myocardial infarction</td>
</tr>
<tr>
<td>h.</td>
<td>Traumatic brain injury</td>
</tr>
<tr>
<td>i.</td>
<td>Anxiety disorder</td>
</tr>
<tr>
<td>j.</td>
<td>Depression</td>
</tr>
<tr>
<td>k.</td>
<td>Manic depression (bipolar disorder)</td>
</tr>
<tr>
<td>l.</td>
<td>Chronic respiratory failure</td>
</tr>
<tr>
<td>m.</td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td>n.</td>
<td>Spina Bifida</td>
</tr>
<tr>
<td>o.</td>
<td>Emphysema / COPD</td>
</tr>
<tr>
<td>p.</td>
<td>Hyperthyroidism</td>
</tr>
<tr>
<td>q.</td>
<td>Hyperlipidemia</td>
</tr>
<tr>
<td>r.</td>
<td>Compare past 31-180 days</td>
</tr>
<tr>
<td>s.</td>
<td>order of magnitude</td>
</tr>
<tr>
<td>t.</td>
<td>Cataracts</td>
</tr>
<tr>
<td>u.</td>
<td>Diabetic retinopathy</td>
</tr>
<tr>
<td>v.</td>
<td>Mental retardation</td>
</tr>
<tr>
<td>w.</td>
<td>Down's syndrome</td>
</tr>
<tr>
<td>x.</td>
<td>Staphylococcus aureus</td>
</tr>
<tr>
<td>y.</td>
<td>Clostridium difficile (c.dif.)</td>
</tr>
<tr>
<td>z.</td>
<td>Viral hepatitis</td>
</tr>
<tr>
<td>A</td>
<td>Nonspecific fever</td>
</tr>
<tr>
<td>B</td>
<td>Unstable gait</td>
</tr>
<tr>
<td>C</td>
<td>Wound infection</td>
</tr>
<tr>
<td>D</td>
<td>Septicemia</td>
</tr>
<tr>
<td>E</td>
<td>NONE OF ABOVE</td>
</tr>
</tbody>
</table>

**SECTION J. HEALTH CONDITIONS**

**J1. PROBLEM CONDITIONS**

Check all problems present in last 30 days unless other time frame is indicated.

INDICATORS OF FLUID STATUS

- Dizziness/Vertigo
- Edema
- Fever
- Hallucinations
- Recurrent lung aspirations in last 90 days
- Shortness of breath
- Syndrome (fainting)
- Unsteady gait
- Vomiting
- NONE OF ABOVE

**J2. PAIN SYMPTOMS**

(Code the highest level of pain present in the last 30 days)

- a. Frequency with which individual complains or shows evidence of pain
  - 0. None
  - 1. Mild pain
  - 2. Moderate pain
  - 3. Severe pain
  - 4. Agonizing pain
  - 5. Excruciating pain

- b. Intensity of pain
  - 0. None
  - 1. Mild pain
  - 2. Moderate pain
  - 3. Severe pain
  - 4. Agonizing pain
  - 5. Excruciating pain

- c. Type of pain
  - 0. None
  - 1. Musculoskeletal pain
  - 2. Gastrointestinal pain
  - 3. Headache pain
  - 4. Neuralgia pain
  - 5. Neurological pain
  - 6. Ocular pain
  - 7. Osteoarthritic pain
  - 8. Peripheral vascular pain

- d. Frequency over the past 30 days
  - 0. None
  - 1. 1% to 25%
  - 2. 26% to 50%
  - 3. 51% to 75%
  - 4. 76% to 100%

- e. Intensity of pain over the past 30 days
  - 0. None
  - 1. Mild pain
  - 2. Moderate pain
  - 3. Severe pain
  - 4. Agonizing pain
  - 5. Excruciating pain

**J3. ACCIDENTS**

- a. Type of accident
  - 0. None
  - 1. Fall in past 30 days
  - 2. Fall in past 31-180 days
  - 3. NONE OF ABOVE

**J5. STABILITY OF CONDITIONS**

Conditions/diseases make individual's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)

- Individual experiencing an acute episode or a flare-up of a recurrent or chronic problem
  - 0. NONE OF ABOVE
  - 1. End-stage disease, 6 or fewer months to live

**SECTION K. ORAL/NUTRITIONAL STATUS**

**K1. ORAL PROBLEMS**

- a. Chewing problem
  - 0. None
  - 1. Yes

- b. Swallowing problem
  - 0. None
  - 1. Yes

- c. NONE OF ABOVE

**K2. HEIGHT AND WEIGHT**

Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days

- a. HT (in.)
- b. WT (lb.)

**K3. WEIGHT CHANGE**

- a. Weight loss—5% or more in last 30 days, or 10% or more in the last 180 days
  - 0. No
  - 1. Yes

- b. Weight gain—5% or more in last 30 days, or 10% or more in the last 180 days
  - 0. No
  - 1. Yes

**K5. NUTRITIONAL APPROACHES**

- a. On a planned weight change program
  - 0. None
  - 1. Yes

- b. Therapeutic diet
  - 0. None
  - 1. Yes

**K6. PARENTERAL OR ENTERAL INTAKE**

- a. Parenteral nutrition
  - 0. None
  - 1. Yes

- b. Therapeutic tube feeding
  - 0. None
  - 1. Yes

**SECTION M. SKIN CONDITIONS**

**M1. ULCERS**

- a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue
  - 0. None
  - 1. Yes

- b. Stage 1 ulcer
  - 0. None
  - 1. Yes

- c. Stage 2 ulcer
  - 0. None
  - 1. Yes

- d. Stage 3 ulcer
  - 0. None
  - 1. Yes

- e. Stage 4 ulcer
  - 0. None
  - 1. Yes

- f. Stasis ulcer—open lesion caused by poor circulation in the lower extremities
  - 0. None
  - 1. Yes

- g. None of the above
  - 0. None
  - 1. Yes

**M2. OTHER ULCERS**

- a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue
  - 0. None
  - 1. Yes

- b. Stage 1 ulcer
  - 0. None
  - 1. Yes

- c. Stage 2 ulcer
  - 0. None
  - 1. Yes

- d. Stage 3 ulcer
  - 0. None
  - 1. Yes

- e. Stage 4 ulcer
  - 0. None
  - 1. Yes

- f. Stasis ulcer—open lesion caused by poor circulation in the lower extremities
  - 0. None
  - 1. Yes

- g. None of the above
  - 0. None
  - 1. Yes
### SECTION P. SPECIAL TREATMENTS AND PROCEDURES

#### P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

<table>
<thead>
<tr>
<th><strong>TREATMENTS</strong></th>
<th><strong>PROGRAMS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Special Care</td>
<td>a. Ventilator or respirator</td>
</tr>
<tr>
<td>b. Chemotherapy</td>
<td>b. Alcohol/drug treatment program</td>
</tr>
<tr>
<td>c. Dialysis</td>
<td>c. Intake/output</td>
</tr>
<tr>
<td>d. IV medication</td>
<td>d. Intake/output</td>
</tr>
<tr>
<td>e. Intake/output</td>
<td>e. Alzheimer's/dementia special care unit</td>
</tr>
<tr>
<td>f. Monitoring acute medical condition</td>
<td>f. Hospice care</td>
</tr>
<tr>
<td>g. Osmotyre care</td>
<td>g. Pediatric unit</td>
</tr>
<tr>
<td>h. Oxygen therapy</td>
<td>h. Respiratory care</td>
</tr>
<tr>
<td>i. Radiation</td>
<td>i. Training in skills required to return to the community (e.g., taking medications, housework, shopping, transportation, ADLs)</td>
</tr>
<tr>
<td>j. Suctioning</td>
<td>j. Psychiatry care</td>
</tr>
<tr>
<td>k. Tracheostomy care</td>
<td>k. NONE OF ABOVE</td>
</tr>
</tbody>
</table>

#### P2. THERAPIES

- Record the number of days and total minutes each of the following therapies was administered (for at least 15 min a day) in the last 30 calendar days (Enter 0 if none or less than 15 min daily) 
- [Note—Count only post admission therapies]

##### P3. NURSING REHABILITATION/RESTORATIVE CARE

- Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the Individual for more than or equal to 15 minutes per day in the last 30 days
- (Enter 0 if none or less than 15 min daily)

##### P4. DEVICES AND RESTRAINTS

- Use the following codes for last 30 days:

<table>
<thead>
<tr>
<th>Device/Restraint</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed rails</td>
<td>✗</td>
</tr>
<tr>
<td>Chairs</td>
<td>✗</td>
</tr>
<tr>
<td>Other types of side rails used (e.g., half rail, one side)</td>
<td>✗</td>
</tr>
<tr>
<td>Trunk restraint</td>
<td>✗</td>
</tr>
<tr>
<td>Limb restraint</td>
<td>✗</td>
</tr>
<tr>
<td>Chair prevents rising</td>
<td>✗</td>
</tr>
</tbody>
</table>

### SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

#### Q2. OVERALL CHANGE IN CARE NEEDS

- Individual overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)
- 0. No change 1. Improved—receives fewer 2. Deteriorated—receives more support

### SECTION R. SIGNATURE/DATE COMPLETED

#### R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

- Signature of RN completing assessment (sign on above line)
- Date Assessment Completed [Month, Day, Year]
SECTION U. MEDICATIONS

List all medications that the individual **received** during the last 30 days. Include scheduled medications that are used regularly, but less than weekly.

1. **Medication Name and Dose Ordered.** Record the name of the medication and dose ordered.

2. **Route of Administration (RA).** Code the Route of Administration using the following list:

   - 1=by mouth (PO)
   - 2=sub lingual (SL)
   - 3=intramuscular (IM)
   - 4=intravenous (IV)
   - 5=subcutaneous (SQ)
   - 6=rectal (R)
   - 7=topical
   - 8=inhalation
   - 9=enteral tube
   - 10=other

3. **Frequency.** Code the number of times per day, week, or month the medication is administered using the following list:

   - PR=(PRN) as necessary
   - 1H=(QH) every hour
   - 2H=(Q2H) every two hours
   - 3H=(Q3H) every three hours
   - 4H=(Q4H) every four hours
   - 5H=(Q5H) every five hours
   - 6H=(Q6H) every six hours
   - 8H=(Q8H) every eight hours
   - 1D=(QD or HS) once daily
   - 2D=(BID) two times daily
   - 3D=(TID) three times daily
   - 4D=(QID) four times daily
   - 5D=five times daily
   - 6D=six times daily
   - 1W=(Q week) once each week
   - 2W=two times each week
   - 3W=three times each week
   - 4W=four times each week
   - 5W=five times each week
   - 6W=six times each week
   - 7W=seven times each week
   - 8W=eight times each week
   - 9W=9 times each week
   - 1M=(Q month) once every month
   - 2M=twice every month
   - 3M=three times every month
   - 4M=four times every month
   - 5M=five times every month
   - 6M=six times every month
   - 7M=seven times every month
   - 8M=eight times every month
   - 9M=nine times every month
   - C=continuous
   - R=rectal
   - I=intramuscular
   - V=intravenous
   - S=subcutaneous
   - L=intraluminal
   - O=oral
   - T=topical
   - H=sublingual
   - P=per os
   - Q=as needed
   - H=hourly
   - D=daily
   - BID=twice daily
   - QID=four times daily
   - TID=three times daily
   - QH=hourly
   - Q12H=twelve hourly
   - Q24H=twenty four hourly
   - Q1W=weekly
   - Q2W=twice weekly
   - Q3W=three times weekly
   - Q4W=four times weekly
   - Q5W=five times weekly
   - Q6W=six times weekly
   - Q7W=seven times weekly
   - Q8W=eight times weekly
   - Q9W=nine times weekly
   - Q1M=monthly
   - Q2M=bi-monthly
   - Q3M=tri-monthly
   - Q4M=quarterly
   - Q6M=six monthly
   - Q12M=twelve monthly

4. **PRN-number of doses (PRN-n).** If the frequency code for the medication is "PR", record the number of doses during the last 30 days each PRN medication was given. Code STAT medications as PRNs given once.

<table>
<thead>
<tr>
<th>1. Medication Name and Dose Ordered</th>
<th>2. RA</th>
<th>3. Freq</th>
<th>4. PRN-n</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td><strong>S1. Medicaid Information</strong></td>
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<td>-------------------------------</td>
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<td></td>
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<tr>
<td><strong>S1a. Medicaid Client Indicator</strong></td>
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<tr>
<td>1. Medicaid</td>
<td></td>
<td></td>
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<tr>
<td><strong>S1b. Admission to Medicaid Date</strong></td>
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<tr>
<td><strong>S1c. Admitted from</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Nursing Facility</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4. State School/Facility</td>
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<tr>
<td>5. Other</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. Cannot Determine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S1d. Individual Address</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S1e. City</strong></td>
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<td></td>
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<tr>
<td><strong>S1f. State</strong></td>
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<tr>
<td><strong>S1g. Zip Code</strong></td>
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</table>

<table>
<thead>
<tr>
<th><strong>S2. Claims Processing Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S2a. DADS Vendor/Site ID</strong></td>
</tr>
<tr>
<td><strong>S2b. Contract/Provider Number</strong></td>
</tr>
<tr>
<td><strong>S2c. Service Group</strong></td>
</tr>
<tr>
<td><strong>S2d. NPI Number</strong></td>
</tr>
<tr>
<td><strong>S2e. Region</strong></td>
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<tr>
<td><strong>S2f. Purpose Code</strong></td>
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<thead>
<tr>
<th><strong>S3. Primary Diagnosis</strong></th>
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<tr>
<td><strong>S3a. Primary Diagnosis ICD-9</strong></td>
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<tr>
<th><strong>S4. For DADS use only</strong></th>
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<tr>
<td><strong>S4a. MN</strong></td>
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<tr>
<td><strong>S4b. RUG</strong></td>
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<tr>
<td><strong>S4c. Effective Date</strong></td>
</tr>
<tr>
<td><strong>S4d. Expiration Date</strong></td>
</tr>
<tr>
<td><strong>S4e. County</strong></td>
</tr>
<tr>
<td><strong>S4f. DADS RN Signature</strong></td>
</tr>
<tr>
<td><strong>S4g. Signature Date</strong></td>
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<table>
<thead>
<tr>
<th><strong>S5. Licenses</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Provider certification: I certify to the completeness of this information</strong></td>
</tr>
<tr>
<td><strong>S5a. DADS RN Last Name</strong></td>
</tr>
<tr>
<td><strong>S5b. DADS RN License #</strong></td>
</tr>
<tr>
<td><strong>S5b1. DADS RN License State</strong></td>
</tr>
<tr>
<td><strong>S5c. HHA RN Last Name</strong></td>
</tr>
<tr>
<td><strong>S5d. HHA RN License #</strong></td>
</tr>
<tr>
<td><strong>S5d1. HHA RN License State</strong></td>
</tr>
<tr>
<td><strong>S5e. DADS UR RN Last Name</strong></td>
</tr>
<tr>
<td><strong>S5f. DADS UR RN License #</strong></td>
</tr>
<tr>
<td><strong>S5f1. DADS UR RN License State</strong></td>
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<tr>
<td><strong>S5g. DADS UR RN Signature Date</strong></td>
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<td><strong>DADS UR RN Signature</strong></td>
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<tr>
<td><strong>S5h. PACE RN Last name</strong></td>
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<td><strong>S5i. PACE License #</strong></td>
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<td><strong>S5i1. PACE RN License State</strong></td>
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<tr>
<td><strong>S5j. HMO RN Last Name</strong></td>
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<tr>
<td><strong>S5k. HMO RN License #</strong></td>
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<tr>
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<tr>
<th><strong>S6. Therapeutic Intervention</strong></th>
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<tbody>
<tr>
<td><strong>S6a. Tracheostomy Care</strong></td>
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<tr>
<td><strong>S6b. Ventilator/Respirator</strong></td>
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<table>
<thead>
<tr>
<th><strong>S7. Physician’s Evaluation &amp; Recommendation</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>S7a. I certify that this individual requires nursing facility services or alternative community based services under supervision of an MD/DO. Y/N</strong></td>
</tr>
<tr>
<td><strong>S7b. MD/DO Last Name</strong></td>
</tr>
<tr>
<td><strong>S7c. MD/DO License #</strong></td>
</tr>
<tr>
<td><strong>S7c1. MD/DO License state</strong></td>
</tr>
<tr>
<td><strong>S7d. MD/DO Military Spec Code</strong></td>
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