State of New Mexico
Medical Assistance Program Manual

# Supplement

HUMAN SERVICES DEPARTMENT

**DATE:** **July 18, 2016** **NUMBER: 16-06**

TO: LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED SERVICE PROVIDERS

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THROUGH: SHARILYN ROANHORSE-AGUILAR, EXEMPT SERVICES & PROGRAMS, BUREAU CHIEF

SUBJECT: CHANGES TO MAD 378 ICF/IID AND DEVELOPMENTAL DISABILITIES HOME & COMMUNITY BASED SERVICES WAIVER LONG TERM CARE MEDICAL ASSESSMENT ABSTRACT FORM

The Long Term Care Medical Assessment form (MAD 378 or "Abstract") is used in the Medicaid program to assess and issue prior authorizations (PA) for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care (LOC). Medical providers (physician, nurse practitioner or physician assistant) use this form to record a patient's medical diagnosis, medications, and assessment factors for daily activities.

The form and instructions have been updated to clarify the signature requirement in box B9 for Case Manager Signature.

Effective immediately, the MAD 378 ICF/IID and Developmental Disabilities Home & Community Based Services Waiver Long Term Care Assessment Abstract Form has been updated. The new form can be located at the Medicaid portal: https://nmmedicaid.acs-inc.com/static/ProviderInformation.html.

If there are further questions, please contact Barbara Czinger at Barbara.Czinger@state.nm.us or 505-827-3176.

HUMAN SERVICES DEPARTMENT

# ICF/IID and DEVELOPMENTAL DISABILITIES HOME & COMMUNITY BASED SERVICES WAIVER
## LONG TERM CARE MEDICAL ASSESSMENT ABSTRACT

*The Information on this form is Confidential*

## A. General Patient Information

| 1. Assessment Type ☐ Initial ☐ Readmit ☐ Reconsider ☐ Continued Stay/Annual ☐ Change ☐ Transfer. | 2. Date of Admission or Completion of Abstract: | 3. Referral Source ☐ DDW ☐ Hosp ☐ ICF ☐ Home ☐ NF ☐ Other | 4. Medicaid Eligibility ☐ Active ☐ Pending |
|---|---|---|---|

| 5. Patient's Name *Last First MI* | 6. Medicaid Number/SSN | 7. Date of Birth | 8. Gender ☐ M ☐ F | 9. Late/Retro ☐ Yes ☐ No |
|---|---|---|---|---|
| | | | | |

## B. General Facility/Mi Via Consultant Agency/Case Management Agency

| 1. Name of Facility or Agency | 2. Mailing Address | 3. Facility Provider Number | 4. Facility NPI Number |
|---|---|---|---|
| | | | |

| 5. Facility Taxonomy # | 6. Contact Name | 7. Contact Fax # | 8. Contact Telephone # | 9. Case Manager Signature |
|---|---|---|---|---|
| | | | | |

## C. Medical Assessment - Physician, Nurse Practitioner or Physician Assistant

**1. DIAGNOSIS/PROBLEMS** - *(One per line) If resident hospitalized since last certification - enter reason:*

| ENTER PRIMARY DD DIAGNOSIS FIRST | ICD-10 Code |
|---|---|
| a. | |
| b. | |
| c. | |
| d. | |

**2. MEDICATION** - *List up to four most important medications, method of administration (MOA) and frequency.*

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

**3. ASSESSMENT FACTORS INDICATING NEED for SPECIALIZED SERVICES.** *Place the appropriate assessment factor and score in the corresponding boxes.*

| Specialized Services | Assessment Factors | Factor Score |
|---|---|---|
| *Physical Therapy* | | |
| *Occupational Therapy* | | |
| *Speech Therapy* | | |
| *Behavior Management* | | |
| *Nursing Care* | | |

**4. SUPPORTING DOCUMENTATION.** *(Please check each document being submitted and include most current date)*

| | | |
|---|---|---|
| *Preliminary Evaluation* | | Date |
| *Comprehensive Functional Assessment* | | Date |
| *Individual Program Plan* | | Date |
| *History and Physical (H & P)* | | Date |
| *Comprehensive Initial Assessment (CIA)* | | Date |

**5. ASSESSMENT FACTORS**

| | |
|---|---|
| **A. Physical Development & Health** | **SCORE** |
| 1. Health Care Supervision | |
| 2. Med Assessment | |
| 3. Med Administration | |
| **B. Nutritional Status** | **SCORE** |
| 1. Eating Skills | |
| 2. Diet Supervision | |
| **C. Sensorimotor Development** | **SCORE** |
| 1. Mobility | |
| 2. Toileting | |
| 3. Hygiene | |
| 4. Dressing | |
| **D. Affective Development** | |
| **E. Speech & Language Development** | **SCORE** |
| 1. Expressive | |
| 2. Receptive | |
| **F. Auditory Functioning** | |
| **G. Cognitive Development** | |
| **H. Social Development** | **SCORE** |
| 1. Interpersonal Skills | |
| 2. Social Participation | |
| **I. Independent Living Skills** | **SCORE** |
| 1. Home Skills | |
| 2. Community Skills | |
| **J. Adaptive Behaviors** | **SCORE** |
| 1. Harmful Behavior | |
| 2. Disruptive Behavior | |
| 3. Socially Unacceptable, Stereotypic | |
| 4. Uncooperative Behavior | |

**6. Total Assessment Factors Score _____ /22 = _____ (ICF/IID Level)**

**7. ICF/IDD Level**
- ☐ 1.0 – 2.2 = Level I/DDW LOC Eligible
- ☐ 2.3 – 2.9 = Level II/DDW LOC Eligible
- ☐ 3.0 – 3.2 = Level III/DDW LOC Eligible

**8. Physician's Name (Print):**

**a. Physician Statement** *I have seen and evaluated this patient and recommend:*
☐ Level I/DDW LOC Eligible ☐ Level II/ DDW LOC Eligible ☐ Level III/DDW LOC Eligible

**b. Physician's Signature** | **c. Date**

**d. Mailing Address** | **City** | **State** | **Zip Code**

## D. THIRD PARTY ASSESSOR / UTILIZATION REVIEW AGENCY SECTION ONLY

| 1. Level of Care ☐ Level I/DDW LOC Eligible ☐ Level II/DDW LOC Eligible ☐ Level III/DDW LOC Eligible | 2. Review Decision ☐ Approved ☐ Denied | 3. LOC Authorization Date Span (Start-End) |
|---|---|---|

| 4. Prior Authorization Number | 5. Reviewer's First and Last Name Initials | 6. Review Date | 7. Date of Discharge |
|---|---|---|---|
| | | | |

**8. Discharged To:** ☐ HOSP ☐ LNF ☐ HNF ☐ LAMA ☐ OTH ☐ HOME ☐ INST ☐ HHA ☐ DIED ☐ DDW

**9. Facility Discharged to:**

**DISTRIBUTION:** **Original** – TPA/UR Agency **Copy** – Facility, Fiscal Agent, ISD County Office

# Instructions for Form – Medical Assistance Division (MAD) 378
# Long Term Care Medical Assessment Abstract

**PURPOSE:** The Long Term Care Medical Assessment Abstract form (MAD 378 or "Abstract") is used in the Medicaid program to assess and issue prior authorizations (PA) for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care (LOC). Medical providers (physician, nurse practitioner or physician assistant) record a patient's medical diagnosis, medications, assessment factors for daily activities. The medical provider attests that the medical records and recommendation for an ICF/IID LOC are accurate. Supplemental medical documentation may be required to support information on the MAD 378.

The completed MAD 378 and any supplemental documentation are evaluated by a Third Party Assessor (TPA) to determine if the patient meets the State's criteria for ICF/IID LOC. When a patient meets the State's ICF/IID LOC and financial eligibility for Medicaid, they may be eligible to receive Medicaid for an ICF/IID stay or Home and Community-Based Services (HCBS) under the Developmental Disabilities Waiver (DDW) including Mi Via self-direction. The MAD 378 is also used to indicate the approved LOC date span.

**INSTRUCTIONS:**

**A – General Patient Information:** This section must contain complete patient identifying and contact information. In **box 1**, "Assessment Type", check "Initial" if this is the first ICF/IID LOC assessment. If the patient has a current ICF/IID LOC, is currently institutionalized or receiving DDW or Mi Via services, and is due for due for an annual reassessment, check "Continued Stay/Annual". A "Continued Stay/Annual" review request must be received by the TPA contractor prior to expiration of the current LOC date span. If the patient has left the ICF/IID and then returns, check "Readmit". If the physician is submitting an updated assessment because the patient's condition has changed to a different LOC, check "Change". All changes in LOC require a new MAD 378 and must be submitted within thirty (30) calendar days of the change in the patient's condition. If the LOC request was denied and the physician is submitting new information to be considered, check "Reconsider". If a patient is transferring to another ICF/IID, check "Transfer". In **box 2**, enter patient's date of admission to the ICF/IID or date abstract completed for DDW or Mi Via LOC consideration. In **box 3**, check the source of patient's referral. In **box 4**, check the current status of the patient's Medicaid eligibility. In **box 9**, check yes if your request for an LOC is late and you are requesting a retrospective LOC authorization.

**B – General Facility or Agency Information:** This section must contain case management agency or ICF/IID facility contact information. In **box 1**, enter name of the ICF/IID facility, name of the Mi Via consultant agency, or DDW case management agency facilitating the assessment. In **box 4**, enter the facility/agency 10-digit National Provider Identifier (NPI) number (no spaces or tabs). In **box 5**, enter the facility taxonomy number (no spaces or tabs). In **boxes 6, 7, and 8** enter the direct contact name, contact fax, and contact phone number for the facility, Mi Via consultant agency, or case management agency. In box 9, enter the case manager signature. For Mi Via Participants the only required information in section B is the name of the Consultant Agency in box 1 and the name of the participant's consultant as the contact name in box 6. A signature for Mi Via consultant agencies is not required in box 9.

**C – Medical Assessment:** This section must contain a patient's medical diagnosis, medications, assessment factors, indication of need for specialized services and the medical provider's attestation and recommendation for ICF/IID LOC. In **box 1**, enter the primary DD diagnosis and corresponding ICD10 code first, in line a.; the current claims reimbursement process now requires this. In **box 2**, list medications, method of administration, and frequency. In **box 3**, enter appropriate assessment factors and scores that indicate a need for the special services listed. NOTE: Factors from box 5 lend themselves to box 3; completion of box 5 prior to completing box 3 may be helpful. Information in box 3 is an assessment of LOC only, NOT an indicator of potential Medicaid services. In **box 4**, check all documents submitted with the Assessment and enter corresponding effective dates. In **box 5**, enter scores for each assessment factor based on the MAD ICF/IID admission criteria. In **box 6**, calculate and enter the Assessment Factors Score and divide by 22 to determine the Level or DDW Eligible. In **box 7**, indicate the Level or DDW LOC Eligible (e.g. if the Assessment Factors Score in box 6 is 55, then the Level or DDW LOC Eligible is 2.5 indicating Level II/DDW LOC Eligible). In **box 8**, all fields are required.

**D – This Section is completed by the TPA/UR Agency. Boxes 1-6 are required. Boxes 7-9 are required for facility discharges only.**

**ROUTING:** For DDW applicants the local case management or consultant agency coordinates with the individual, parent or guardian in order for the patient's physician to finalize the assessment process and sign/date the form. After completion, the MAD 378 is forwarded to the TPA for processing.

If the MAD 378 or supplemental medical documentation is incomplete *(required information is missing)*, the TPA will issue a request for information (RFI) to the provider. If the TPA determines that the patient does not meet ICF/IID LOC, the TPA will mail the referring parties a denial letter with the reason of denial as determined by the physician consultant. Providers who are dissatisfied with the TPA's medical necessity decision(s) may request reconsideration (see 8.350.2 NMAC). Patients who disagree with the ICF/IID LOC denial can request a Fair Hearing within (90) calendar days of the date of the notice of action (see section 8.352.2 NMAC, Recipient Hearings).

The TPA will fax copies of the completed MAD 378, inclusive of the UR decision to the appropriate Income Support Division (ISD) office, ICF/IID or Agency, and the Medicaid Fiscal Agent or MCO, as appropriate.

**FORM RETENTION:** Permanent.