CLE FOR ALJS AND SHOS AT 330 WEST 34TH ST, MANHATTAN

Topic: Long Term Home Health Care Program

Place: 330 West 34th Street, NY, NY (Room 1104)

Date: June 12, 2007

Time: 1:30pm to 3:00pm

This course will be eligible for 1.5 hours of non-transitional credits in Areas of Professional Practice

Attendance: All ALJs and SHOs stationed at our 34th St office are expected to attend unless excused by their supervisor.

AGENDA
June 12, 2007
(Total Time: 90 min)

1. Background/Brief Overview of LTHHCP/Lombardi
2. AIDS Home Care Program- subset of Lombardi Program
3. LTHHCP/Lombardi Eligibility Criteria
4. Required Assessment
    - Process
    - Players involved and roles - HRA & Provider
    - Forms used - DMS-1, Home Assessment Abstract (DOH-3139)
5. DMS-1 Form
    - score determines nursing home eligibility and level of care required
    - documentation of need for medical oversight/coordinated care
    - use of physician override
6. Authorization Process & Client Noticing
7. Reassessment/Reauthorization Process & Client Noticing
8. Differences of Opinion/Dispute Resolution
9. Case examples of appropriateness for Lombardi versus Home Attendant Program
10. HRA mandate relief history and current HRA status
11. Question and Answer period

Handouts:
NYCRR Title 18 Section 505.21
Policy 83 ADM-74 (details assessment process)
Policy 02 OMM/ADM-4
DMS-1 Form and Instructions

Resource:
LTHHCP Reference Manual (June 2006) can be found at:

http://www.health.state.ny.us/health_care/medicaid/reference/lthhcp/
(See DOH/Other Resources on FHDMS Home Page)

CLE

Long Term Home Health Care Program

June 12, 2007

Biographies

18 NYCRR 505.21 Long Term Home Health Care Programs; AIDS Home Care Programs

02 OMM/ADM-4 Notice and Fair hearing Procedures for the Long Term Home Health Care Program

83 ADM-74 Implementation of Chapter 895 of the Laws of 1997 and Chapter 636 of the Laws of 1980: Long Term Home Health Care Program

Biographies

Diane R. Jones

Has two years of experience in the State Department of Health in administering various aspects of New York State's Medicaid funded home and community-based services and programs, including but not limited to: Long Term Home Health Care Program (LTHHCP) and Hospice Program. Has over 25 years of nursing experience including supervision, education, inpatient and home care. She has a B.S. in Nursing

Doreen Sharp

Registered Nurse with many years of experience in acute care as well as outpatient primary care. Worked for the State Department of Health since 1998; has been involved in Medicaid policy/ program development including, but not limited to, Medicaid Disability Review and community based long term care related to home health care services, hospice, and the Long Term Home Health Care Program (LTHHCP).

Jane McCloskey

Jane McCloskey is an Associate Attorney with the newly formed Bureau of Health Insurance Programs within the Department of Health's Division of Legal Affairs, which provides counsel and litigation support to the Department's also recently formed Office of Health Insurance Programs with respect to Medicaid, managed care, long term care, Child Health Plus, EPIC and reimbursement issues. From 1985 to 1996, she was a Senior Attorney with the Bureau of Medicaid Law with the former NYS Department of Social Services, specializing in home care and other long term care and related litigation, and performed similar responsibilities when the Medicaid program was transferred to the Department of Health in 1996.

New York Code, Rules and Regulations

Title: Section **505.21** - Long term home health care programs; AIDS home care programs.

505.21 Long term home health care programs; AIDS home care programs.

(a) Definitions. (1) Long term home health care program (LTHHCP) means a coordinated plan of care and services provided at home to invalid, infirm or disabled persons who are medically eligible for placement for an extended period of time in a hospital or residential health care facility (RHCF) if the LTHHCP were unavailable. Such program can be provided in the person's home, including an adult care facility other than a shelter for adults, or in the home of a responsible relative or other responsible adult.

(2)(i) AIDS home care program (AHCP) means a coordinated plan of care and services provided at home to persons who are medically eligible for placement in a hospital or an RHCF and who are diagnosed by a physician as having acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV)related illness as defined by the AIDS Institute of the State Department of Health. Such definitions are contained in directives issued by the department from time to time.

(ii) An AHCP can be provided only by a LTHHCP provider specifically authorized under article 36 of the Public Health Law to provide an AHCP as a discrete part of the LTHHCP.

(iii) An AHCP can be provided in the person's home, which includes an adult care facility specifically approved to admit or retain residents for such program, the home of a responsible relative or other responsible adult, or in other residential settings as approved by the Commissioner of Health in conjunction with the Commissioner of Social Services.

(3) Government funds means funds provided under the provisions of title 11 of article 5 of the Social Services Law (medical assistance to needy persons).

(b) Assessment and authorization. (1) (i) If a LTHHCP, as defined under article 36 of the Public Health Law, is provided in the social services district for which he or she has authority, the local social services official, before he or she authorizes care in an RHCF, must notify the person in writing of the availability of the LTHHCP.

(ii) If an AHCP, as defined under article 36 of the Public Health Law, is provided in the social services district for which he or she has authority, the local social services official, before authorizing RHCF care, home health services, or personal care services for a person with AIDS, must notify the person in writing of the availability of the AHCP. If the person desires to remain and is deemed by his or her physician able to remain in his or her own home if the necessary services are provided, such person or his or her representative must so inform the local social services official, who must authorize an assessment under the provisions of section 3616 of the Public Health Law and paragraph

(2) of this subdivision. If the results of the assessment indicate that the person can receive the appropriate level of care at home, the official must prepare for that person a plan for the provision of services comparable to services that would be rendered in a hospital or an RHCF, as appropriate for the person. In developing such plan, the official must consult with those persons performing the assessment and must assure that such plan is appropriate to the person's needs and will result in an efficient use of services.

(2) If a person who has been assessed in accordance with section 505.9(b) of this Part by a LTHHCP or an AHCP, a physician or discharge planner or, at the option of the social services district, another certified home health agency, as needing care in an RHCF or a hospital, desires to remain and is deemed by his or her physician able to remain in his/her own home or the home of a responsible relative or other responsible adult or an adult care facility, other than a shelter for adults, if the necessary services are provided and, for purposes of an adult care facility, the person meets the admission and continued stay criteria for such facility, the social services district must authorize a home assessment of the appropriateness of LTHHCP or AHCP services. The assessment must include, in addition to the physician's recommendation, an evaluation of the social and environmental needs of the person. The assessment will serve as a basis for the development of an appropriate plan of care for the person.

(i) If the person is in a hospital or an RHCF, the home assessment must be performed by the person's physician, the discharge coordinator of the hospital or RHCF referring the person, a representative of the social services district, and a representative of the LTHHCP or AHCP that will provide services to the person.

(ii) If the person is in his/her own home, the home assessment must be authorized by the social services district and must be performed by the person's physician, a representative of the social services district, and a representative of the LTHHCP or AHCP that will provide services to the person.

(iii) The assessment must be completed prior to or within 30 days after the provision of services begins. Payment for services provided prior to the completion of the assessment may be made only if it is determined, based upon such assessment, that the person qualifies for such services.

(iv) If the person is in an adult care facility, the home assessment must be performed by representatives of the LTHHCP or AHCP and the social services district in consultation with the operator of the adult care facility.

(v) Persons provided LTHHCP or AHCP services in adult care facilities must meet the admission and continued stay criteria for such facilities.

(vi) For persons requesting LTHHCP or AHCP services in adult care facilities, assessments must be completed prior to the provision of services.

(vii) Services provided by the LTHHCP or AHCP must not duplicate or replace those which the adult care facility is required by law or regulation to provide.

(viii) The commissioner must prescribe the forms on which the assessment will be made.

(3) If there is disagreement among the persons performing the assessment, or questions regarding the coordinated plan of care, or problems in implementing the plan of care, the issues must be reviewed and resolved by a physician designated by the Commissioner of Health.

(4) At the time of the initial assessment, and at the time of each subsequent assessment performed for a LTHHCP, or more often if the person's needs require it, the social services district must establish a monthly budget in accordance with which payment will be authorized. The social services district must provide the operator of the adult care facility with a copy of the completed assessment, the plan of care and the monthly budget.

(i) For persons who neither reside in adult care facilities nor receive AHCP services:

(a) The budget must include all of the services to be provided in accordance with the coordinated plan of health care by the LTHHCP.

(b) Total monthly expenditures made for a LTHHCP for a person who is the sole member of his/her household in the program must not exceed a maximum of 75 percent of the average monthly rates payable for RHCF services in the social services district. Total monthly expenditures made for a LTHHCP for two members of the same household must not exceed a maximum of 75 percent of the average monthly rates payable for both members of the household for RHCF services in the social services district.

(c) When the monthly budget prepared for a person who is the sole member of his/her household in the program is for an amount less than 75 percent of monthly rates payable for RHCF services, a "credit" may be accrued on behalf of the person. If a continuing assessment of the person's needs demonstrates that he/she requires increased services, the social services district may authorize any amount accrued during the past 12 months over the 75 percent maximum. When the monthly budget prepared for two members of the same household is for an amount less than 75 percent of monthly rates payable for RHCF services, a "credit" may be accrued on behalf of the household. If a continuing assessment of the household's needs demonstrates that the household requires increased services, the social services district may authorize any amount accrued during the past 12 months over the 75 percent maximum.

(d) When the monthly budget prepared for a person or a household is for an amount less than 75 percent of monthly rates payable for RHCF services, and the continuing assessment of the person's or household's needs demonstrates that the person or household requires increased services in an amount less than 10 percent of the prepared monthly budget, but totaling no more than 75 percent of the monthly rates payable for

RHCF services, the LTHHCP may provide such services without prior approval of the social services district.

(e) If an assessment of the person's or household's needs demonstrates that the person or household requires services, the payment for which would exceed such monthly maximum, but it can be reasonably anticipated that total expenditures for required services for such person or household will not exceed such maximum calculated over a one-year period, the social services official may authorize payment for such services.

(ii) For persons residing in adult care facilities but not receiving AHCP services:

(a) The budget must include all of the services to be provided in accordance with the coordinated plan of health care by the LTHHCP.

(b) Total monthly expenditures made for LTHHCP services provided to a person residing in an adult care facility must not exceed a maximum of 50 percent of the average monthly rates payable for RHCF services in the social services district.

(c) When the monthly budget prepared for a person residing in an adult care facility is for an amount less than 50 percent of the average of the monthly rates for RHCF services, a "credit" may be accrued on behalf of the person. If a continuing assessment of the person's needs demonstrates that he/she requires increased services, the social services district may authorize the expenditure of any amount accrued during the past 12 months provided that such amount, when added to the amount previously expended, does not exceed the 50 percent maximum.

(d) When the monthly budget prepared for a person residing in an adult care facility is less than 50 percent of the monthly rates payable for RHCF services, and the continuing assessment of the person's needs demonstrates that he/she requires increased services in an amount less than 10 percent of the prepared monthly budget, but totaling no more than 50 percent of the monthly rates payable for RHCF services, the LTHHCP may provide such services without prior approval of the local social services district.

(e) If an assessment of the needs of an adult care facility resident demonstrates that services are required, the payment for which would exceed the monthly maximum specified in clause (b) of this subparagraph, but it can be reasonably anticipated that total expenditures for required services for such person will not exceed such maximum calculated over a one-year period, the social services official may authorize payment for such services.

(iii) For persons receiving AHCP services, total monthly expenditures for such services are not subject to the requirements of subparagraph

(4)(i) or (ii) of this subdivision.

(5) If a joint assessment by the social services district and the provider of services under

this paragraph indicates that the maximum expenditure permitted under paragraph (4) of this subdivision is not sufficient to provide LTHHCP services to persons with special needs, social services officials may authorize, pursuant to the provisions of section 367-c(3-a) of the Social Services Law, maximum monthly expenditures for such persons, not to exceed 100 percent of the average RHCF rate established for that district. In addition, if a continuing assessment of a person with special needs demonstrates that he/she requires increased services, a social services official may authorize the expenditure of any amount which has accrued under this section during the past 12 months as a result of the expenditures for a person participating in the LTHHCP not having exceeded such maximum. If an assessment of a person with special needs demonstrates that he/she requires increased services, the payment for which would exceed such monthly maximum, the social services official may authorize payment for such services if it can reasonably be anticipated that the total expenditures for the required services for such a person will not exceed the maximum calculated over a one-year period.

(i) As used in this subdivision, the term person with special needs means a person for whom a plan of care has been developed pursuant to subdivision 2 of section 367-c of the Social Services Law:

(a) who needs care including but not limited to respiratory therapy, tube feeding, decubitus care or insulin therapy which cannot be appropriately provided by a provider of personal care services as defined in section 505.14(d) of this Part; or

(b) who has one or more of the following conditions: a mental disability as defined in section 1.03 of the Mental Hygiene Law, acquired immune deficiency syndrome, or dementia, including Alzheimer's disease.

(ii) The number of persons with special needs for whom a social services official may authorize payment for services pursuant to this paragraph is limited to 25 percent of the total number of LTHHCP clients which a social services district is authorized to serve; provided that in any district containing a city having a population of one million or more, such limit is 15 percent.

(iii) In the event that a district reaches the limitation specified in this subparagraph, the social services official may, upon approval by the commissioner, authorize payment for services pursuant to this subdivision for additional persons with special needs.

(iv) The social services official must seek approval for authorization to serve additional persons with special needs by submitting a written request to the commissioner which demonstrates that the provisions of this paragraph have (a) met the needs of individuals who could not otherwise be served through the LTHHCP; (b) diverted clients from residential health care facility admission; or (c) permitted the admission of clients on alternate care status into the LTHHCP.

(v) Social services districts are responsible for the retention of information deemed necessary by the department to evaluate the effectiveness of raising the limitation on

expenditures for the delivery of long term home health care services, and for compliance with reporting requirements established by the department.

(vi) The provisions of this paragraph remain in effect until December 31, 1993.

(6) When a person who is in a hospital or an RHCF is identified as being medically eligible for hospital or RHCF care, and who desires to return to his/her own home and is deemed by his/her physician as able to be cared for at home, an assessment must be completed, and authorization for LTHHCP or AHCP services or notification that the person is ineligible for such program must be timely made with respect to ensuring continued Federal reimbursement.

(7) The social services district is responsible for the general case management of the overall needs of the person. Case management includes:

(i) facilitating determination of financial eligibility for medical assistance;

(ii) involvement in the assessment and reassessment of the social and environmental needs of the person;

(iii) preparation of the monthly budget for persons other than those receiving AHCP services; and

(iv) coordination of LTHHCP or AHCP services and other social services which may be required to keep the person in his/her own home.

(8) No single authorization for LTHHCP or AHCP services may exceed four months.

(i) A reassessment must be performed at least every 120 days, and must include an evaluation of the medical, social and environmental needs of the person, and must include a representative of the LTHHCP or AHCP, a representative of the social services district, and a physician designated by the Commissioner of Health. If there is a change in the person's level of care, he/she must be notified in writing of such change.

(ii) If a change in the person's level of care occurs between assess
ment periods as recommended by the LTHHCP or AHCP, the social services district must be notified and a new assessment must be authorized.

(c) Requirements for provision of care. (1) Home health aide services may be provided directly by a LTHHCP or by an AHCP, or through contract arrangements between the LTHHCP or AHCP and voluntary agencies or proprietary agencies.

(2) Personal care services may be provided directly by a LTHHCP or an AHCP, or through contract arrangements between the LTHHCP or AHCP and the social services district or voluntary or proprietary agencies.

(3) In addition to providing nursing services to the person receiving LTHHCP or AHCP services, the LTHHCP's or AHCP's registered professional nurse or professional therapist must also be assigned responsibility for the supervision of the person providing personal care services to evaluate the person's ability to carry out assigned duties, to relate well to persons receiving LTHHCP or AHCP services, and to work effectively as a member of a team of health workers. This supervision must be carried out during periodic visits to the home in accordance with policies and standards established by the Department of Health.

(4) Services of a registered professional nurse or professional therapist and supervision of persons providing personal care services may be carried out concurrently. The frequency of periodic visits must be determined by the coordinated plan of care, but in no case may they be less frequent than every 120 days.

(d) Payment. (1) Payment for a LTHHCP or an AHCP must be at rates established for each service for each agency authorized to provide the program. Rates must be on a per-visit basis, or, in the case of home health aide services and personal care services, on an hourly basis.

(2) (i) When personal care services are directly provided by a LTHHCP or an AHCP, or when they are provided through contract arrangements with an agency that does not have a rate negotiated with the social services district, the Department of Health will establish the rate of payment with the approval of the Department of Social Services and the Director of the Budget.

(ii) When personal care services are provided by a LTHHCP or an AHCP through contract arrangements with a social services district, computation of the budget must be based on the district's salary schedule, but no payment may be made to the LTHHCP or AHCP.

(iii) When personal care services are provided by a LTHHCP or an AHCP through contract arrangements with an agency that has a rate negotiated with the social services district, the LTHHCP or AHCP rate must be no higher than that locally negotiated rate.

(3) Payment for assessment for a LTHHCP or an AHCP:

(i) is included in the hospital rate for staff participation in discharge planning;

(ii) is included in the physician's visit fee if the physician is not on the hospital staff, and performs the initial assessment while the person is in the hospital;

(iii) is included in the physician's home visit fee when the initial assessment or reassessment is performed in the person's home;

(iv) is included in the physician's office visit fee when the initial assessment or reassessment is performed in a nonfacility-related physician's office; and

(v) is included in the clinic fee when the initial assessment or reassessment is performed in a clinic or outpatient department.

(4) LTHHCP or AHCP participation in initial assessment and reassessment must be included in the administrative costs of the program.

(5) No social services district may make payments pursuant to title XIX of the Federal Social Security Act for benefits available under title XVIII (Medicare) of such Act without documentation of the following:

(i) that the LTHHCP or AHCP has prepared written justification for not having made application for Medicare because of the person's apparent technical ineligibility; or

(ii) that application for Medicare benefits has been rejected by either the Health Care Financing Administration or its fiscal intermediary.

(6) No social services district may make payment for a person receiving LTHHCP or AHCP services while payments are being made for that person for inpatient care in an RHCF or a hospital.

(e) Reimbursement. State reimbursement shall be available for expenditures made in accord with the provisions of this section.

Volume: C

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 02 OMM/ADM-4

TO: Commissioners of Social Services

DIVISION: Office of Medicaid Management

DATE: May 28, 2002

SUBJECT: Notice and Fair Hearing Procedures for the Long Term Home Health Care Program

SUGGESTED DISTRIBUTION:	Directors of Social Services Home Care Staff Medicaid Staff Long Term Home Health Care Programs Fair Hearing Staff Legal Staff
CONTACT PERSON:	Any questions concerning this release should be directed to Dorah Bluth, Bureau of Long Term Care, by calling (518) 474-5271
ATTACHMENTS:	Long Term Home Health Care Program Fair Hearing Notices Physician Confirmation Form See Appendix I for a listing of attachments

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
83 ADM-74	GIS 01-MA-035	18 NYCRR 505.21	SSL 367-C		

I. PURPOSE

The purpose of this Directive is to advise Local Departments of Social Services (LDSS) and Long Term Home Health Care Programs (LTHHCP) of new fair hearing procedures. These procedures relate to LTHHCP participants' existing as well as new fair hearing rights. With respect to LTHHCP participants' existing fair hearing rights, this Directive includes fair hearing notices that districts must send under the following circumstances described in 83 ADM-74: when the Medicaid recipient's application for participation in the LTHHCP is denied; when the recipient's participation in the LTHHCP is discontinued; and, when there is a change in the recipient's level of care budget cap from Skilled Nursing Facility (SNF) to Health Related Facility (HRF). With respect to LTHHCP participants' new fair hearing rights, this Directive describes the additional fair hearing rights now required when a LDSS or a LTHHCP proposes to deny, discontinue or reduce one or more services in the recipient's plan of care, **contrary to treating physician's orders,** but does not propose to terminate the recipient's participation in the LTHHCP.

II. BACKGROUND

Under 83-ADM-74, LTHHCP applicants/recipients were entitled to notice and fair hearing rights under the three circumstances described above. The Department's previous ADMS required districts to develop their own notices. To assure uniformity, the Department has now developed standard notices that districts must send when they or the LTHHCP propose to deny a Medicaid recipient's application to participate in the LTHHCP, to discontinue the recipient's participation in the LTHHCP or to reduce the level of care budget from SNF to HRF.

In addition, this Directive implements new fair hearing rights consistent with stipulations in the Simmons v. DeBuono (Supreme Court, Erie County, 2000) and Bernard v. Novello (E.D.N.Y.,2001)cases. Under these new procedures, LTHHCP recipients are entitled to notice and fair hearing rights when a LDSS or a LTHHCP proposes to deny, reduce or discontinue one or more services in the LTHHCP participant's plan of care contrary to his or her treating physician's orders, but does not propose to terminate the recipient's participation in the LTHHCP. In GIS 01-MA-035, the Department previously provided fair hearing notices for the specific services involved in the Simmons and Bernard litigation (personal care, home health aide, and physical therapy). A recipient may also request a fair hearing when other services in the LTHHCP plan of care are denied, discontinued or reduced contrary to the treating physician's orders (e.g., occupational therapy). To simplify the notices, the Department has developed a general notice which must be used whenever a service in the recipient's LTHHCP plan of care is denied, discontinued or reduced contrary to the recipient's treating physician's orders. Districts should use these notices and discontinue use of the notices set forth in GIS 01-MA-035.

III. PROGRAM IMPLICATIONS

Previous fair hearing requirements outlined in 83 ADM-74 required LTHHCP applicants/recipients to be provided timely notice and fair hearing rights when the LDSS or the LTHHCP:

- denies the application for participation in the LTHHCP;
- discontinue the recipient's participation in the LTHHCP; or
- changes the budgeting level of care for a current LTHHCP participant from SNF to HRF.

These rights will not be affected by the addition of the rights outlined in this Directive.

The additional rights are:

- LTHHCP recipients are entitled to fair hearing rights when the number of hours of Medicaid funded services previously authorized under their care plans is reduced or discontinued **contrary to their treating physicians' orders**.
- LTHHCP recipients are entitled to fair hearing rights when Medicaid funded services are denied **contrary to their treating physicians' orders**.
- LTHHCP recipients are entitled to fair hearing rights under 18 NYCRR section 358-3.1(b)(6) to review the adequacy of their Medicaid funded services.

IV. REQUIRED ACTION

A. NOTIFICATION REQUIREMENTS FOR LTHHCP & LDSS

1) Notices for Existing Fair Hearing Rights

Prior to issuance of this Directive, the Department had not provided fair hearing notices to be used when the LDSS or the LTHHCP denied an application for participation in the LTHHCP, discontinued a recipient's participation in the LTHHCP or when the budgeting level of care changed from SNF to HRF. To assure statewide uniformity, all fair hearing notices for LTHHCP applicants/recipients have been prepared and are appended to this Directive as attachments.

All the notices included as attachments to this Directive have two versions. Attachments followed by an **A** contain the fair hearing phone numbers for all districts other than New York City. Attachments followed by a **B** contain fair hearing phone numbers for New York City only. Each LDSS must use the appropriate notice for that particular district.

Attachment I, "Notice of Intent to Authorize/Reauthorize or Deny Your Participation in the Long Term Home Health Care Program", is to be used to notify an LTHHCP applicant/recipient that a decision has been made to authorize, reauthorize or deny his or her application to participate in the LTHHCP.

Attachment II, "Notice of Intent to Discontinue Your Participation in the Long Term Home Health Care Program (LTHHCP)", is to be used when participation in the LTHHCP is discontinued.

Attachment III, "Notice of Intent to Reduce Your SNF Level Budget To An HRF Budget In The Long Term Home Health Care Program," is to be used when the budgeting level used to determine the budget cap for a recipient changes from Skilled Nursing Facility (SNF) to Health Related Facility (HRF).

2) **New Procedures and Fair Hearing Notice for Reductions or Discontinuances of Services within the LTHHCP**

When the LDSS (or LTHHCP) intends to reduce or discontinue one or more services being provided to a LTHHCP recipient, but does not propose to discontinue the recipient's participation in the LTHHCP itself, the following action must be taken before the LTHHCP may implement the proposed reduction or discontinuance of the service:

a) The LDSS must consult with the recipient's physician, as set forth in (b), below, to determine whether the physician agrees with the proposed reduction or discontinuance of the service. Alternatively, the LDSS may request that the LTHHCP consult with the recipient's physician, as set forth in (b), below. Regardless of whether the LDSS or the LTHHCP assumes responsibility for consulting with the physician, the LDSS and the LTHHCP must communicate closely with each other regarding the recipient's case and the proposed reduction or discontinuance. Close communication and coordination is vital to assure that both the LDSS and the LTHHCP are cognizant of whether the physician agrees, or disagrees, with the proposed reduction or discontinuance since the physician's decision governs whether the LDSS must send the recipient the timely and adequate notice of the proposed action with the right to request a fair hearing with aid-continuing that is appended to this directive as Attachment V, described in (2)(d), below.

b) The LDSS must obtain a written statement from the recipient's physician that indicates whether the physician agrees or disagrees with the proposed change in the recipient's care plan. The Department has developed the Physician Confirmation Form for this purpose. The Physician Confirmation Form is appended to this directive as **Attachment IV**. The LDSS must use this form, which is to be printed on legal-size paper, or request the Department's approval to use a different form. The LDSS may, alternatively, request that the LTHHCP obtain the written statement from the recipient's physician. When the LTHHCP agrees to obtain this written statement, the LDSS must advise the LTHHCP that the LTHHCP must also use the Physician Confirmation Form or request the Department's approval to use a different form. The LDSS (or the LTHHCP) must send the Physician Confirmation Form (or a Department approved equivalent) to the recipient's physician

and request that the physician complete and return the form within 10 business days. The Physician Confirmation Form contains a space for the LDSS (or the LTHHCP) to indicate the person to whom the physician should return the form, together with such person's telephone and fax numbers. It is preferable that the physician be requested to return the Physician Confirmation Form directly to the LDSS; however, should the form be returned to the LTHHCP, the LTHHCP must notify the LDSS immediately of the physician's determination whether he or she agrees or disagrees with the proposed reduction or discontinuance. The physician's decision governs whether the LDSS must send the recipient the fair hearing notice appended to this directive as Attachment V.

c) When the physician agrees with the proposed reduction or discontinuance of the recipient's service, the LDSS must notify the LTHHCP that the LTHHCP may implement the proposed reduction or discontinuance. The LDSS is not required to send the recipient a timely and adequate notice with fair hearing and aid-continuing rights. However, the LTHHCP should advise the recipient, in accordance with existing procedures and requirements established pursuant to 10 NYCRR Part 763, of the change in the recipient's service.

d) When the physician disagrees with the proposed reduction or discontinuance, or fails to return the Physician Confirmation Form, the LDSS must send the recipient the fair hearing notice that is appended to this directive as **Attachment V**, and which is entitled "Notice of Intent to Reduce or Discontinue Services in the Long Term Home Health Care Program (LTHHCP) Contrary To Physician's Orders." The LDSS must use this notice when it proposes to reduce or discontinue services in the LTHHCP contrary to the recipient's treating physician's order but the recipient's participation in the LTHHCP will not be terminated. The LDSS must also send the LTHHCP a copy of the fair hearing notice. The LDSS must also advise the LTHHCP that it may not reduce or discontinue the service before the effective date of the notice and, if the recipient requests a fair hearing with aid-continuing prior to the effective date of the notice, the LDSS must also advise the LTHHCP that it may not reduce or discontinue the service pending issuance of the fair hearing decision.

Attachment V, "Notice of Intent to Reduce or Discontinue Services in the Long Term Home Health Care Program (LTHHCP) Contrary To Physician's Orders," is to be used when services will be discontinued or reduced in the LTHHCP contrary to the treating physician's orders, but the recipient's participation in the LTHHCP will not be terminated.

e) The LDSS must notify the LTHHCP immediately if aid continuing is granted for discontinued or reduced services, and instruct the LTHHCP to continue services unchanged pending the fair hearing determination.

3) **Notices for Denials**

When the LDSS or LTHHCP intends to deny a service contrary to physician's orders, the LDSS is required to send the appropriate notice, below, with fair hearing rights to the recipient. The LDSS must send a copy of the notice to the LTHHCP so it has a copy for its records.

Attachment VI, "Notice of Intent To Deny Services In The Long Term Home Health Care Program Contrary To Physician's Orders," is to be used when services will be denied in the LTHHCP contrary to the treating physician's orders, but the recipient's participation in the LTHHCP will not be terminated

B. REQUIREMENTS FOR FAIR HEARING NOTICES

When completing fair hearing notices, LDSS must include a brief description of the action the district intends to take and the specific reason for such action.

The notices provided with this Directive are mandated and must be reproduced by the LDSS until such time as the notices are printed and become available from the Department. The notices must be on legal size paper and must be reproduced as two sided notices rather than two-paged notices. Any modification to these notices must be submitted in accordance with procedures described in 97 ADM-13, "Procedure for Requesting Approval of Local Equivalent Forms".

IMPORTANT: The notices provided as part of this Directive are in two versions: attachments followed by an **A** have the fair hearing phone numbers used by districts other than New York City; attachments followed by a **B** have the fair hearing phone numbers for New York City. The LDSS must use the appropriate notice for that particular district.

V. SYSTEMS IMPLICATIONS

None

VI. EFFECTIVE DATE

Immediately

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET ALBANY NEW YORK 12243

CESAR A. PERALES
Commissioner

[An Administrative Directive is written communication to local Social Services Districts providing directions to be followed in the administration of public assistance and care programs.]

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL NO.. 83 ADM-74
[Income Maintenance]

TO: Commissioners of Social Services

SUBJECT: Implementation of Chapter 895 of the Laws of 1977 and Chapter 636 of the Laws of 1980: Long Term Home Health Care Program

DATE: December 30 1983

SUGGESTED DISTRIBUTION: All Medical Assistance Staff
All Services Staff

CONTACT PERSON: Any questions concerning this release should be directed to Bill Mossey, Division of Medical Assistance, by calling (800)342-3715, extension 3-5600. (See Appendix A, summary of revisions made in previous administrative directive, 78-ADM-70.)

I. PURPOSE

The purpose of this release is to acquaint districts with provisions of the major home care legislation of 1977 chapter 895 of the Laws of 1977 and chapter 636 of the Laws of 1980: The New York State LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP).

Among the topics included in this release are:

— a description of the work flow, or order of activities, with respect to the provision of care under this title;

— descriptions of social services responsibilities at each stage of the process; and,

— an explanation of how the Medicare maximization effort applies to services provided under this title.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Social Services Law and Other Legal References	Bulletin/Chapter Reference	Miscellaneous Reference
78 ADM-70		505.21	367 C SS Law 3600 PH Law 162 Ins. Law		

DSS 296 (REV 8/82)

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II. BACKGROUND

The development of less costly alternatives to institutional care and methods to help the chronically ill or disabled and the infirm elderly maintain a degree of independence are issues of national concern which have gained importance in recent years. In New York State, this concern was reflected in Chapter 918 of the laws of 1972, which brought home health care into the mainstream of the health care system by defining the term "home health agency" in Article 36 of the Public Health Law and incorporating the establishment of such agencies in the certificate of need mechanism.

Effective April 1, 1978, New York State initiated a new program designed to provide an alternative for patients who are medically eligible for skilled nursing and intermediate care to stay in their own homes. The legislation is intended to provide a vital stimulus to the use of home care services by coordinating home care programs and making their availability known to potential users of the system. The underlying philosophy of the legislation is that proper delivery of health care at home can assist in changing the approach to providing services for elderly patients in institutional settings by preventing premature institutionalization for individuals who can be cared for at home.

The impetus for development and passage of this legislation was the atmosphere of growing need for long term care by New York State residents and the escalating costs of long term care. The number of elderly in the state is rising and concentrations of this age group can be found in central cities and older suburbs. The need, however, to develop services for chronically ill or elderly frail individuals is statewide, in rural as well as urban areas. Further, the state's five- year deinstitutionalization plan for mental hygiene patients has had, and will continue to have, an impact on the number of long term care beds available. The inappropriate admissions of individuals not in need of skilled nursing or intermediate care, as well as admissions of those who could be cared for at home, has further contributed to the scarcity of available care, and to the escalating cost of institutional care.

It is generally conceded that the increasing frequency with which families, particularly during the past decade, have looked to institutional forms of care for their aged and chronically ill relatives is a reflection of not only the weakening of traditional family ties, but also of the family's fears that adequate forms of care simply do not exist outside the skilled nursing and intermediate care facilities. These fears are recognized as having contributed significantly to the growth of institutional long term care. This program aims to offer a legitimate alternative to institutionalization for those who desire this option and can meet the qualifications.

The costs of financing a health care industry which emphasizes institutional care are enormous. There are, for example, 70,932 skilled nursing beds in New York State and 26,263 intermediate care beds. The average per diem rate for Medicaid patients in those beds in 1982 was $73.98 and $47 05, respectively A survey revealed that the daily average number of patients across the state awaiting alternate care arrangements in hospitals is approximately 4,500. The average cost per day of caring for

those patients was $250. Medicaid expenditures for skilled nursing care in fiscal year 1980-81 was approximately $1.1 billion, and for intermediate care facilities $318 million.

III. PROGRAM IMPLICATIONS

A. Chapter 895 of the Laws of 1977 and Chapter 636 of the Laws of 1980

In the statement of intent, it is clearly indicated that this legislation represents a commitment to provide high quality home care services as an alternative to placement in either skilled nursing or health related facilities, recognizing that early provision of services to these patients and the families that support them has a preventive effect in institutionalizing patients. The legislation proposes to achieve this objective through the establishment of Long Term Home Health Care Programs (LTHHCP), the primary purpose of which will be the provision of coordinated home care services to recipients who are medically eligible for care in an institutional setting.

The following features are included in the legislation:

1. A Long Term Home Health Care Program (LTHHCP) is a coordinated plan of care and services provided at home to invalid, infirm or disabled persons who are medically eligible for placement in a skilled nursing facility or health related facility, as determined by the New York State Department of Health Form DMS-1 or its successor

   A LTHHCP may be provided by a certified home health agency (public or voluntary non-profit organization) as certified under Article 36 of the Public Health Law. A LTHHCP may also be provided by a residential health care facility (skilled nursing facility or health related facility) or hospital currently certified under Article 28 of the Public Health Law. However, no such agency, facility or hospital may provide a LTHHCP without the written authorization of the State Health Commissioner Accordingly, some certified home health agencies may be authorized to provide a LTHHCP as well as the traditional kind of home health care services they are now providing.

2. A LTHHCP is required to provide nursing, medical social services and home health aide services, medical supplies and equipment, all other therapeutic and related services (e.g. physical therapy, speech therapy, respiratory therapy, nutritional counseling, and personal care services including homemaker and housekeeper). In addition, a LTHHCP may provide seven waived services (home maintenance tasks, home improvement services, respite care, social day care, social transportation, home delivered meals, and moving assistance). An example of the way in which these services may be made available would be that a LTHHCP might contract with an approved Social Day Care Program or a certified moving

company in order to provide a LTHHCP patient with a suitable home and adequate socialization.

3. LTHHCP services may be provided in a person's own home or in the home of a responsible relative, but not in a private proprietary home for adults, private proprietary convalescent home, residence for adults, or public home.

4. LTHHCP services can be provided to both Medicaid and non-Medicaid recipients who have been assessed as medically eligible for care at either the skilled nursing or health related facility level.

5. In addition to the financial eligibility of Medicaid users and medical eligibility of all potential users of LTHHCP services, there are two other limitations on coverage:

   a. A LTHHCP will be available only in social services districts where there are such programs authorized by New York State Department of Health.

   b. LTHHCP services may be authorized when the total expenditures for health and medical services called for in the comprehensive plan of care do not exceed, on an annual basis, 75% of the monthly cost of care in either a skilled nursing facility or a health related facility in the district, whichever is the appropriate level of care for the individual. The average monthly rate for each level of care in individual counties will be computed by the New York State Department of Health.

      When the total monthly expenditure for all health, social and environmental services available under the program exceeds the 75% monthly maximum, LTHHCP services may be authorized if it can be reasonably anticipated that the total yearly expenditures will not exceed 75% of the yearly cost of care in a skilled nursing facility or health related facility. (The determination of the cost of care for an individual is described in Section IV-F, Required Action - Preparation of the Budget, pp. 17-19.)

6. An important LTHHCP feature is the use of a comprehensive and coordinated assessment process to formulate a summary of the required services and a plan of care.

   a. Assessment Processes - Two distinct assessment processes are required for each individual prior to the development of summary of services requirements for the individual.

      1. Medical Assessment - This is the initial assessment process and is accomplished by the completion and scoring of the DMS-1 or its successor This is also

the tool that is used as an indicator for need for SNF or HRF placement. Once this determination has been made and the physician and patient approve of the home care option, a second assessment process is authorized by the local social services district.

Note: Physician Override-A physician override is necessary when a patient's predictor score does not reflect the patient's true level of care. For example, a patient with a low predictor score may require institutional care due to emotional instability or safety factors. The patient's physician designee or the local professional director may give the override.

ii. Home Assessment - This second assessment is done in order to determine now, and if, the patient's total health and social care needs, as well as those prescribed by the physician, can be met in the home environment. It is accomplished by the joint completion of the Home Assessment Abstract (Appendix B) or its successor by the nurse representative of the LTHHCP and the professional caseworker from the LDSS. It is from the completed Home Assessment Abstract that a summary of services requirements and a plan of care shall be developed.

There are two approaches to performing the home assessment:

— LTHHCP nurse representative and a local department of social services case manager complete a joint home assessment. The local social services district then completes the summary of service requirements and social services authorization prior to the delivery of LTHHCP services or,

— The LTHHCP representative completes a preliminary assessment; based upon this assessment develops a proposed summary of service requirements and delivery of services. However, LTHHCP services are not authorized until the local social services district and the LTHHCP complete a joint home assessment. The LDSS then completes a summary of

service requirements and makes a determination as to service authorization within 30 days of receipt of the written referral. In the event that either the patient is ineligible for the program or any of the services delivered are inappropriate, the LTHHCP will be financially responsible for these unauthorized services. Both home assessment approaches are described further in Section III B Program Implications - Work Flow pp. 7-9.

b. Summary of Service Requirements is a listing of the types, frequency, and amounts of services which will be necessary to maintain the patient at home in accordance with the physician's orders and the joint assessment. This listing can be found on the Home Assessment Abstract and should represent all the services - medical, nursing, social work, therapies, health aide, personal care, homemaking, housekeeping, drugs, and all other support services - which will be "packaged" as part of the total services to be delivered to the patient.

c. Plan of Care is an internal, practical, clinical document (developed by the LTHHCP) describing the care to be given to the patient. This plan of care based on the summary of service requirements is drawn up by the nurse from the LTHHCP, includes goals and objectives for the patient and the staff and outlines the methodology and procedures which will be employed to reach those goals. It is a dynamic working document of the LTHHCP and will be part of each patient's record.

B. Work Flow (Process)

The following is a listing of the activities which will be associated with the provision of LTHHCP services in the order they should normally occur for potential and active medicaid clients.

1. The client, or someone on his behalf, indicates that he believes the client is eligible for the LTHHCP, or that the client is medically eligible for SNF or HRF level care.

2. A health and functional status assessment (Office of Health System Management Form DMS-1 or its successor) is completed and scored.

3. If a client is assessed as eligible for skilled nursing or health related care, and a Long Term Home Health Care Program exists in the district, the client must be made aware in writing that the services provided under this title are available as an option to the client.

NOTE. Districts must provide notification at this point to all such potential clients. It will frequently be in the client's, as well as the district's, best interest to notify individuals even earlier of the possibility of their being eligible to receive LTHHCP services. Each district must develop a formal process to assure timely client notification.

4. The client (and/or his family, representative, etc.) must indicate whether or not he is interested in receiving LTHHCP services. If he is not interested, all activities related to this program cease. If he is interested, preparation is made for the LTHHCP home assessment.

5. For all clients indicating they desire LTHHCP services, and for whom the responsible physician has indicated that home care can appropriately meet their needs, the responsible social services district shall assure that physician's orders be obtained and require that a home assessment be done.

As mentioned above, there are two different approaches to completion of the home assessment process. Paragraphs number 6-11 outline the activities for the first approach (the joint LTHHCP/local social services district assessment and authorization prior to the delivery of services) and paragraphs number 12-19 outline the activities for the second approach (the LTHHCP assessment and delivery of LTHHCP services prior to the joint assessment and DSS authorization).

Joint DSS/LTHHCP Assessment Prior to Delivery of Service:

6. The home assessment is completed on a Home Assessment Abstract form (or its successor) by representatives of both the LTHHCP and Social Services.

7 A summary of services requirements, based on the joint assessment and the physician's orders, is developed, the construction of which is the joint responsibility of the Department of Social Services, the Long Term Home Health Care Program, and when the patient is currently in a hospital or other facility, the discharge coordinator

8. Should the responsible physician determine that the client's health and safety needs simply cannot be met in a home care setting, the client shall be deemed inappropriate for care under this title.

9. Following development of the final summary of service requirements which list specific kinds and amounts of service to be provided, a budget review will be initiated by the local department of social services. Budget review, in this sense, means a review of the monthly cost of care to determine whether or not the total cost is within 75% of the appropriate monthly average cost for

care in a skilled nursing facility, or health related facility, whichever is appropriate. If the local social services district determines that the total yearly expenditures for providing care are not expected to exceed 75% of the yearly cost of care for a skilled nursing or health related facility, the local district may authorize LTHHCP services.

10. Upon completion of the summary of service requirements, and the social services budget determination, LDSS authorizes services and notifies the LTHHCP to begin providing care. In the event that the local DSS budget determination finds the costs of care exceeding the 75% ceiling on an annual basis, the local district continues to be responsible for finding alternative care options.

    NOTE. Upon approval or denial of LTHHCP services authorization, Right to Fair Hearing Notice must be made to client in accordance with existing regulation and procedures (See Section O, p. 28)

11. The LTHHCP nurse representative is responsible for setting up health goals for the patient as well as the plan of care and specifying how service will be delivered within the home as well as assuring that staff delivering such service are doing so in a capable, effective and consistent goal-directed manner LDSS staff will retain responsibility for social services management as described in Section IV.J, Local Social Services District Management Responsibility, p. 22.

Service Delivery Prior to a Joint Assessment and DSS Authorization

12. The LTHHCP representative performs a preliminary assessment based upon physician's orders and develops a proposed summary of service requirements.

13. Following the development of proposed summary of service requirements and approval by the physician, a LTHHCP representative will determine whether or not the total cost of care is within either the monthly 75% maximum or the annualized 75% maximum allowable in the LTHHCP

14. If after reviewing the proposed summary of service requirements and service costs the LTHHCP representative has determined that the patient is a suitable candidate for the LTHHCP, then the LTHHCP may decide to provide LTHHCP services prior to LDSS authorization.

15. Since the joint DSS/LTHHCP assessment must be completed prior to or within thirty days after LDSS receives written notification, the LTHHCP should notify the local district as soon as possible. This notification

should immediately be followed by a written notification which includes at a minimum:

a. Patient identification data (address, social security number, Medicaid number, and Medicare eligibility information).

b. Referral source.

c. DMS-1, completed and scored.

d. Physician orders.

e. Proposed summary of service requirements and LTHHCP budget determinations.

16. Within 30 calendar days from the receipt of a referral, the LDSS shall complete the LTHHCP eligibility determination and notify the LTHHCP concerning this decision. This eligibility determination shall be done in the same manner described above in the first assessment approach (numbers 6-11). In other words, there will be a joint DSS/LTHHCP assessment, formulation of a summary of service requirements, budget determination, LDSS authorization and implementation of a plan of care.

17 LDSS authorizations shall be retroactive to the start of the service.

18. As with the other assessment approach, LDSS is responsible for finding alternative care options for patients determined ineligible for the program.

19. The provider will be financially responsible for non-authorized LTHHCP services and all services provided to patients whom LDSS deems ineligible for the program.

20. If LDSS is late in completing assessments, the provider will only be financially responsible for non-authorized LTHHCP services provided through the thirty day period.

IV REQUIRED ACTION

This section is intended to provide further clarification of the local district's responsibilities for medicaid eligible patients at key points in the process described above. More specifically:

A. Assessment to Determine SNF or HRF Eligibility

If a LTHHCP, as defined under Article 36 of the Public Health Law, exists in a given social services district, the LDSS official must, before considering authorization for care in either a skilled nursing or health related facility offer LTHHCP services to all individuals for whom home care is deemed appropriate. The method of determining

who might appropriately receive care under this title involves the assessment to determine the individual's level of care needs. The assessment tool used at this stage is the DMS-1 or its successor, and its purpose is to establish whether the individual is medically eligible for an SNF or HRF

LDSS should develop a process for patients now receiving personal care services to identify those who might better be served by the LTHHCP Once these plans have been identified, the local district may initiate a medical assessment (DMS-1) and if appropriate, a home assessment.

The initial assessment will most commonly occur in one of two settings: when the person is a patient in a hospital, or when the person is living in his own home, or the home of a responsible relative or friend.

If the person is currently a patient in a hospital, SNF, or HRF, the DMS-1 or its successor, will be completed in the same fashion as it is currently done, most frequently by the discharge planner However, if the person is currently in his own home or the home of a relative or responsible adult, the DMS-1 or its successor will most often be completed by the LTHHCP nurse representative or by the patient's physician.

B. Offer of Services

If after the completion of a DMS-1 or its successor, it is indicated that the patient is medically eligible for SNF or HRF level care, and if there is a LTHHCP in the social services district, the local social services official must notify the person both verbally and in writing of the availability of the LTHHCP In addition, when there is a request for care in an SNF or HRF, and the individual has been assessed as requiring that level of care, provision must be made for verbal and written notification of the availability of LTHHCP services. Local social services districts may coordinate their efforts toward timely verbal notification of the existence of the LTHHCP in appropriate cases by working with discharge planners in facilities within their districts.

Verbal notification as to LTHHCPs should also be timely and given to patients and their families as early after admission as feasible. Notification to a patient's family is especially important when the patient's condition is such that he may be unable to fully comprehend or assimilate future planning needs and projections.

Written notification of the availability of this program is mandatory for all patients who are SNF/HRF eligible if there is a program operating in the patient's place of residence. (See DSS Forms 3057 and 3058 - Appendix D DSS Form 3057 is required for patients in an institutional setting at the time of notification; DSS Form 3058 is for patients in a home/residence setting at the time of notification.) (Place of residence refers to the place where a patient will be

receiving services.)

While the offer of services as described above is mandatory for the patients being deemed SNF/HRF appropriate, it is suggested that actual notification be given as early as possible upon a patient's hospital admission if it is anticipated that SNF or HRF level of care may be needed on a long term basis after discharge. This may be determined by the patient's physician and/or the discharge planner taking into consideration the patient's diagnosis and anticipated needs. The timely notification of the LTHHCP as an option to institutionalization is imperative if the tide toward placing persons in facilities is to be stemmed.

C. Home Assessment

The assessment of the appropriateness of the LTHHCP in meeting the medical, psycho-social and environmental needs of the patient begins after the following steps have been completed:

1. patient (and family) have indicated a desire to utilize the LTHHCP in order that the patient can remain at home;

2. the physician has concurred that home care is appropriate for the patient;

3. the completed DMS-1 or its successor indicates eligibility for SNF or HRF level of care; and, either

4. the LDSS has authorized the initiation of the home assessment, or anticipating that the client is an appropriate candidate, the LTHHCP initiates a preliminary assessment to be followed within thirty days by a joint home assessment.

The objective of the Home Assessment Abstract (or its successor) is to determine the appropriateness of the home environment in relation to the care the patient will require from the LTHHCP and the feasibility of delivering such care within that setting. Furthermore, it is from a completed Home Assessment Abstract that the summary of service requirements is developed.

The assessment is seen as a collaborative effort between the LTHHCP which will be providing service to the patient and the LDSS. Frequently one of these parties (LTHHCP or DSS) will have had prior contact with the patient which will facilitate the assessment process. In addition, the hospital discharge planner will frequently be able to provide valuable input in the assessment process and in developing the summary of services required by the patient.

The assessment should be accompanied by physician's orders. The orders should be documented on a form which includes the physician's signature.

It shall be the responsibility of the LTHHP nurse to assure that the

orders are written clearly and concisely and reflected on page 4 of the Home Assessment Abstract.

D. Development of a Summary of Service Requirements

Upon joint completion of the Home Assessment Abstract by the nurse from the LTHHCP and the LDSS representative, a list of services needed by the patient must be developed which will adequately meet the patient's health and social service requirements. This summary of service requirements will be used by the LTHHCP nurse to devise a plan of care for the patient. This plan of care will outline specific therapeutic health and social services to be delivered, as well as patient and therapy goals.

The location of the patient will determine who participates in the home assessment process and the development of the summary of service requirements as follows:

1. If a person is currently a patient in a hospital or SNF or HRF

   a. the patient's physician;

   b. the discharge coordinator of the hospital or SNF or HRF,

   c. a representative of the LDSS; and

   d. a nurse representative of the LTHHCP which will be providing services to the patient.

2. If the person is currently in his/her own home, or the home of a relative or a responsible adult:

   a. the patient's physician;

   b. a representative of the LDSS, and

   c. a nurse representative of the LTHHCP which will be providing services to the patient.

E. Extent of Involvement

Each member of the "team" involved in the medical assessment, home assessment and summary of service requirements has specific responsibilities:

1. Physician - The importance of the physician's understanding and acceptance of the LTHHCP as well as an awareness of how the program functions, its capabilities and limitations, cannot be overemphasized. The physician's responsibilities include:

   a. when involved in the initial assessment (DMS-1 or its successor); the physician must indicate whether or not he deems the patient appropriate for participation in the LTHHCP;

b. may participate in the assessment process;

c. provides specific written medical orders to authorize delivery of health services by the LTHHCP;

d. must renew all medical orders every sixty days; and

e. participates, if only by written renewal of orders, in the reassessment process every 120 days.

2. Discharge Planner - Participation by this person implies that the patient is currently in a hospital, SNF or HRF When appropriate, discharge planners work closely with the patient's physician and the facility nursing staff in formulating their input into the summary of service requirements. Responsibilities may vary in different facilities but may include:

a. providing the initial verbal/written notification of availability of LTHHCP to patients and families. (Often the discharge planner may suggest the appropriateness of the LTHHCP to the patient's physician thereby initiating the whole process);

b. completing DMS-1 or its successor, using data from the patient's medical record and in consultation with the physician and the nursing staff;

c. collaborating in completing the home assessment with the nurse representative of the LTHHCP and the DSS representative;

d. collaborating in completing summary of service requirements in conjunction with the nurse representative of the LTHHCP and the DSS representative; and

e. collaborating with nursing staff of the LTHHCP in drawing up the plan of care.

3. DSS Representative - Ideally this person, who participates in the completion of the Home Assessment Abstract will continue his/her involvement with the patient by assuming the responsibility for social services management for LTHHCP authorized patients and providing for continuity of care by this follow-through management. Specific tasks of the LDSS representative as the patient prepares to enter the LTHHCP and during the initial stages in the program include:

a. assuring initial verbal and written notification to patient and family of availability of LTHHCP or assuring that this has been done in a timely fashion by consultation with the facility discharge planner;

b. assuring that DMS-1 or its successor is complete and indicative of a level of care (SNF or HRF) which the LTHHCP is to provide;

c. assuring determination of Medicaid eligibility for potential LTHHCP clients;

d. requiring the initiation of the home assessment to determine appropriateness of the patient's home environment in relation to his/her medical, nursing, social and rehabilitative needs;

e. providing the social/environmental input into the home assessment process which shall include family interviews, home visits and collaboration and consultation with the LTHHCP nurse representative with whom the Home Assessment Abstract is jointly completed;

f. after developing the summary of service requirements, determines whether LTHHCP services are sufficient to meet the recipient's needs. If the patient requires the provision of other services necessary to maintain him/her in the home environment which are not part of the service package of the LTHHCP provider, but are otherwise available in the community, the LDSS case manager will work cooperatively with the representative of LTHHCP to assure that such services are provided to the patient. Such service provision may include services to other family or household members;

g. the preparation of a monthly or annualized budget for the patient to coincide with needs and to ascertain if the cost of care is within the 75% budget cap as specified within the State Medical Handbook. District specific SNF and HRF level budget caps are at present set annually, as of January 1, and are in effect for an entire calendar year If the patient is not admitted to the LTHHCP, DSS involvement and responsibility continue and an alternative mode of care must be arranged.

h. providing overall case management as described in Section J below;

i. participating in the reassessment procedure every 120 days and visiting the patient in his/her home at least that often. Also authorizes reassessments if notified by the LTHHCP of a need to change the level of care.

4. Representative from the LTHHCP to be Providing Service -This person will be a registered professional nurse assigned to supervision of the case within the LTHHCP The LTHHCP nurse representative will be directly responsible for and/or assuring the following:

a. May be responsible for completing a preliminary assessment and determining a patient's potential eligibility for the LTHHCP prior to the joint assessment;

b. collaborating with the DSS representative in completing the Home Assessment Abstract with special emphasis on health care needs;

c. establishing goals for the patient and methodology for achieving these goals by a practical nursing care plan which clearly outlines the nursing, home health aide and personal care services and other therapeutic and supportive modalities. The plan should also outline the methodology of approach and practical applications. The goals should be well defined, measurable, and updated and re-evaluated at each reassessment period (120 days) and whenever indicated. This nursing care plan should be available to all providers of service and should encourage patient input and family participation;

d. assuring via the nursing plan of care, that the physician's orders are carried out, that care is documented, and that medical orders are renewed every sixty days;

e. notifying the LDSS representative of any change in the level of care in order to facilitate authorization for a reassessment;

f. visiting the patient for periodic reassessment at least every 120 days in order to observe relationships between providers of care and patient environment and general condition;

g. may be responsible for delivery of direct nursing services;

h. providing supervision of persons providing home health aide and personal care services. This includes evaluating the ability of these persons to carry out assigned duties, to relate well to patients and to work effectively as a member of a team of health workers with particular attention to being able to carry out the plan of care.

Although they may be more frequent, the supervisory visits shall be carried out at least once every two weeks for home health aides and once every three months for personal care services. These visits should include the following:

(1) an evaluation of the extent to which health care services included in the plan of care have been adequately delivered;

(2) observation of the patient's surroundings and general condition in relationship to the goals of the plan of care;

(3) checking completion of patient reports; outlining all care given to patient, all changes in patient's condition and noting any indication for change in plan or revision of goals; and

(4) observation concerning the relationship between the person providing service and the patient and providing patient's family. Special attention should be given toward maintenance of family support of the patient within the program in the realization that such support is essential in the success of the LTHHCP

i. coordinating the delivery of all LTHHCP services and working cooperatively with the DSS case manager to integrate into the patient care plan any service provided through the LDSS.

F Preparation of the Budget

1. Services included in a budget preparation: the computation of a LTHHCP budget should be based upon the cost of services listed in the summary of service requirements (Section 16 of the Home Assessment Abstract) regardless of payment source (Medicaid, Medicare, etc.) The following services are considered.

a. Physician Services - An estimate should be made of the frequency of physician visits which will be required by the patient. This should include referrals, if any, to specialists or scheduled clinic visits;

b. Nursing Services - The summary of service requirements will include the frequency of nursing visits for treatment and supervision, and will be paid at rates for the LTHHCP established by the Office of Health Systems Management;

c. Therapies - The summary of service requirements will include the type and frequency of therapies which will be used by the patient. Therapies will be paid at rates established by the Office of Health Systems Management;

d. Podiatry Services - The summary of service requirements will include the type and frequency of the podiatry services which will be used by the patient and all podiatric equipment. The services and equipment will be paid according to the fee schedule established by the Office of Health Systems Management.

e. Drugs - Those which are prescribed by the patient's physician will be noted in the summary of service requirements and will be paid in accordance with the prices listed by the Department of Social Services.

f. Personal Care Services - Will be provided or arranged by the LTHHCP, and the scope and frequency of such services will be noted in the summary of service requirements;

i. When such services are arranged for through voluntary or proprietary home care agencies, the services shall be paid for at rates already negotiated by the local social services commissioner and in addition shall include administrative overhead.

ii. When such services are arranged for through homemaker staff of the local social services district, the LTHHCP shall not bill for the service, but a prorated share of the salary (including the cost of fringe benefits) of the individual providing service shall be included in the monthly budget.

iii. When such services are provided directly by the LTHHCP, the services shall be paid for at rates established by the New York State Department of Health.

g. Transportation - Ambulance service to and from an accredited hospital (as defined in Article 28 of the Public Health Law) and transportation to medicaid reimbursable services normally provided in a RHCF include but are not limited to physician, dental, laboratory, and x-ray The cost of these services will be based on local prevailing charges or locally negotiated fees.

h. Other General Items called for in the summary of service requirements, such as disposable medical supplies, should be estimated as closely as possible based on the local district's experience from submission of claims by pharmacies and suppliers.

i. Durable Medical Equipment called for in the summary of service requirements, such as a bed or wheelchair, may require a single outlay at the initiation of the program or require a monthly rental fee. The cost of purchased items may be annualized for purposes of the monthly budget. (The cost may be divided by 12, and included in the budget for one year.)

j. Waived Services - As a result of Federal waivers and New York State Law, LTHHCP may offer their patients services not normally covered under the current New

York State Medicaid program. When the New York State Department of Social Services has approved the LTHHCP's waivered service delivery plan, including reimbursement rates for all or any one of the services, the LTHHCP may provide one or more of the following services approved in that plan.

— Nutrition Counseling and Education*
— Respiratory Therapy*
— Medical Social Services*
— Home Maintenance Tasks
-- Respite Care
— Social Day Care
— Transportation
— Congregate Meal Services
— Moving Assistance
-- Housing Improvement

* The provision of these services is required by Health Department Regulations.

k. The costs associated with the initial assessment are not included in the monthly budget, and are described in Section N. 1. below, page 28.

l. Items which are not included in the summary of service requirements, and are required infrequently and incidentally, are not included in the monthly budget. Examples of such items are eyeglasses, hearing aides, dentures, or prostheses.

m. Other items which represent unusual expenses, not normally included in RHCF rates, may also be excluded from the budget. These items may include such services as kidney dialysis, radiation therapy, chemotherapy, and the cost of medical transportation to these services. However, since the items included in RHCF rates vary from local district to local district, the LDSS should check with New York State Department of Social Services prior to excluding any item from the patient's budget.

2. Preparation of the Monthly Budgets - Authorizations based upon monthly budgets require that the local social services district compute the monthly service costs based upon the services listed in the summary of service requirements. The monthly budget service costs shall be based upon Medicaid rates established by the Office of Health Systems Management and New York State Department of Social Services. When Medicare is the payor, the Medicare paid amount must be included in the budget. If the recipient of LTHHCP services uses services in an amount less than the 75% monthly ceiling, a "paper credit" should be accrued on his/her behalf to be used in the event of a

period of higher service needs. If the recipient budget and corresponding paper credit computation will be prorated to match the portion of the month that the patient is on the program. (e.g. for a patient admitted on June 15, the June ceiling will be one half the monthly 75% cap.)

3. Preparation of an Annualized Budget - An annualized budget determination may be made during the initial authorization or anytime after the local DSS and the LTHHCP have determined that all the patient's monthly accrued "paper credits" have been utilized and the monthly care expenditures will continue to exceed the 75% ceiling.

Authorizations based upon an annualized budget require that the LDSS and the LTHHCP determine and show in writing that the yearly cost of services in the 12 month period following the date of the assessment is not expected to exceed 75% of the annual cost of either SNF or HRF care.

The LDSS and LTHHCP should consider the following items and document their consideration on the Home Assessment Abstract for the annualized budget:

a. The anticipated changes in patient status that would result in a decrease in the cost of care, (e.g. anticipated improvements in the patient's medical condition or projections concerning a patient's or family's ability to learn and assume a larger part of his health care).

b. The anticipated changes in the patient's service needs (e.g. identifying expensive items that will represent a one time cost, identifying a service that the patient will no longer require).

c. Each annualized budget should be reassessed 120 days following the date of initial authorization. At this time, the LDSS and LTHHCP will determine whether the projected changes in the patient status and service needs have taken place.

d. In anticipating whether an annualized budget is appropriate for a patient, consideration should be given but not limited to the following types of patients:

1. Patients for whom the monthly costs of meeting their health and medical services exceed 75% monthly ceiling but for whom it may be reasonably anticipated that there will be one time high cost items. Such items might include expensive medical equipment, moving assistance or housing improvements.

2. Patients who will require expensive health and

medical services for a limited period of time, (e.g. a recent stroke patient requiring short term physical therapy services or a newly diagnosed diabetic patient requiring skilled nursing instruction for a limited period of time).

4. Additional Budget Determinations - It is understood that the cost of every item of medical assistance for each recipient in the LTHHCP cannot be anticipated in advance. Accordingly, unexpected costs may be incorporated into the monthly budget retroactively.

The provision of these unanticipated services will require local social services district's prior approval only when their costs exceed 10% of the 75% monthly cap.

The local social services district should authorize a reassessment when the patient's monthly budget exceeds the 75% cap by more than 10% for two consecutive months and the accrued payee credits have been used. This reassessment should determine whether the patient is eligible for LTHHCP services based on an annualized budget determination as described above.

If it is determined that the individual's needs will continue to require medical services in excess of both the monthly and yearly ceilings, LTHHCP services are no longer appropriate, alternate arrangements should be made at that time. This statement should not be misconstrued to mean that if a patient's needs cost out to over 75%, he/she must be institutionalized. Where feasible, other forms of home care may be considered.

G. Solving Differences of Opinion

If there is a difference of opinion among the persons performing the assessment concerning the kind or amount of care to be provided, the projected annualized budget, the summary of services required or the delivery of services, the issue may be referred by either party for review and resolution by the local professional director as designated within the area office of the Office of Health Systems Management, State Department of Health. In the case where this individual is not a physician or where there is no local professional director, the State Commissioner of Health shall designate a physician to act in this capacity.

H. Periodic Reassessments

After the initial medical and home assessments, development of the summary of service requirements and implementation of the plan of care, there will be a complete reassessment done every 120 days for each patient. Therefore, no single authorization for Long Term Home Health Care Program services may exceed 120 days.

The reassessment shall include the total re-evaluation of the current health, medical, nursing, social, environmental and rehabilitative needs of the patient by:

1. a nurse representative of the Long Term Home Health Care Program that is providing service to the patient. This nurse may be the person providing the coordination of the case and is responsible for assuring that the reassessment process is within the proper time limits and is done in an efficient professionally accepted manner including revision of nursing goals and updating of plan of care;

2. a representative of the local social services department who may be the case manager and who shares in the responsibility for assuring timeliness of the reassessment process. Additionally, the DSS representative is responsible for all budgeting considerations or changes in the monthly budget which may evolve from a reassessment of needs of the patient;

3. the local professional director or physician designee may also participate in the reassessment process at least to the extent that he/she denotes medical approval of the reassessment and/or any change in the summary of service requirements arising from differences of opinion.

   The tool for the periodic reassessment procedure and any resultant change in service requirements should be the DMS-1 or its successor and the Home Assessment Abstract. Copies of all such reassessments shall be in the patient's record at the LTHHCP as well as at the LDSS.

I. Change in Level of Patient Care Needs

If the patient's condition changes to such a degree that the patient moves from one budget level to another (e.g. HRF to SNF), the local social services department shall be notified at the earliest possible time after the changes are observed. The change in budget level should be verified by documented completion of a new DMS-1 or its successor "Earliest possible time" means the first working day following the noting of a change in the patient's condition.

In collaboration with the LTHHCP, the local social services district shall prepare a revised Home Assessment Abstract, a new summary of service requirement, and monthly budget.

The physician or the nurse representative of the Long Term Home Health Care Program will usually observe and report the necessity for change in budget level, but the responsibilty for notifying the local social services department shall rest with the Long Term Home Health Care Program that is delivering services to the patient.

J Local Social Services District LTHHCP Management Responsibilities

Social Services Management is an integral component of the LTHHCP. This Management combined with the LTHHCP provider Management provides the patient with a coordinated package of services.

1. Patient Notification

The local social services district management responsibility starts with the development of a notification process which assures that all potential LTHHCP recipients or their families are advised concerning the availability of LTHHCP services verbally and in writing.

2. Management of LTHHCP cases

For each potential and active LTHHCP patient, the local social services district must designate one individual who will be accountable for the completion and/or performance of the various management responsibilities listed below:

a. Medicaid Eligibility Application and Recertification:

Assisting with the Medicaid eligibility and recertification procedures and assuring that potential and active LTHHCP patients are financially eligible for Medicaid. This shall include but not be limited to:

- assisting the patients in securing the appropriate documentation and information;

- monitoring the status of the Medicaid Application (certification and application); identifying missing documents and/or information; and notifying the LTHHCP provider and patient appropriately; and

- notifying the provider and patient concerning Medicaid acceptance, denial or discontinuance; dates of Medicaid coverage; and the amount of monthly surplus income.

b. Physicians' Orders and DMS-1

Assuring that the LTHHCP providers obtain necessary medical documentation of service need, including physician's recommendation and level of care assessment, DMS-1 (or its successor).

c. Home Assessment.

Authorizing the initial Home Assessment to determine the appropriateness of a LTHHCP

Completing, in conjunction with the nurse from the

LTHHCP, the Home Assessment Abstract which may include family interviews, home visits and consultation with the nurse from the LTHHCP concerning the social/environmental aspects of the individual's needs.

d. Budget Computations:

Computing the monthly and/or annual budget based upon the completed summary of services requirements in the Home Assessment Abstract for comparison with appropriate ceiling; maintaining any "paper credit" accruing on behalf of the individual.

e. Authorization for LTHHCP Services:

Authorizing LTHHCP services and notifying the provider concerning admission dates.

f. Referral to Alternate Services When Patients are Determined Ineligible for LTHHCP:

With the assistance of the LTHHCP provider, referring ineligible patients to alternate services and assuring that appropriate services are provided.

g. Provision of Non-LTHHCP Services:

Assisting the LTHHCP provider in arranging for the delivery of other services not available in the LTHHCP (adult protective services, legal counseling, recreation therapy, financial counseling, friendly visitors and/or telephone reassurance).

h. Reassessment:

Participating in the periodic reassessment (every 120 days) procedure on an ongoing basis and in the event of a change in the patient's care needs.

i. Changes in Plan of Care:

Incorporating any change in the summary of service requirements into the monthly budget and authorizing any changes which exceed the authorized budget by more than 10% or fifty dollars (whichever is greater), and adjusting paper credits.

j. Monitoring:

Monitoring to assure that LTHHCP services are provided within the 75% cap; in cooperation with the LTHHCP provider monitoring to assure services are provided in accordance with the summary of service requirements.

k. Relationship with the Patient and Family.

Maintaining a positive relationship with the patient and the family. This includes clearly identifying the names and telephone numbers, and responsibility of Social Services personnel, who will be contacting the patient. It also includes supporting the family's involvement in the program. (Maintenance of this relationship should not be taken as a substitute for the provision of Medical Social Services to the patient or family; rather it should be seen as adjunctive to and with the full knowledge and support of the LTHHCP provider.)

K. Long Term Home Health Care Program Provider Management Responsibilty

In addition to the actual provision of services, LTHHCP providers have management responsibilities. These responsibilities include the following:

1. Medicaid Eligibility Application and Recertification:

Assisting the patient in completing forms and securing appropriate documentation.

2. Physician Orders and DMS-1.

Obtaining necessary physician orders and the DMS-1 or its successor

3. Home Assessment:

Completing, in conjunction with the social services representative, the appropriate sections of the Home Assessment Abstract.

4. Referral to Alternate Services when Patients Determined Ineligible for LTHHCP.

Assisting the LDSS in referring patients determined ineligible for the program to appropriate alternatives, and assisting the local social services district to assure that such services are provided.

5. Provision of LTHHCP and Non-LTHHCP Services:

Coordination of the provision of LTHHCP Services (nursing, home health aide, physical therapy, etc.) and with the assistance of the local social services district, non-LTHHCP Services (adult protective services, legal counseling, financial counseling, etc.).

6. Reassessment:

Participating in the periodic reassessment (every 120 days) procedure on an ongoing basis and in the event of a change in the patient's care needs.

7 Changes in Plan of Care:

Notifying the local social services districts the first working day following the noting of a change in the patient's condition and concerning any changes in the authorized summary of services. Seeking prior authorization for any service change which exceeds by 10% or more the 75% cap for the patient.

Notifying the local social services district concerning hospital admissions and other changes in status that might indicate the need for discharge.

L. Maximization of Medicare Benefits

1. Medicare Maximization:

Chapter 895 of the Laws of 1977 states that no Medicaid payment shall be made for benefits available under Medicare without documentation that Medicare claims have been filed and denied. Since the LTHHCP or any approved Medicaid provider subcontracting for certain services for the LTHHCP will be the only Medicaid billing source, each will be expected to assume responsibility for the Medicare maximization effort.

All LTHHCPs should have established Medicare home health provider status. Certified home health agencies will already have this status; some residential health care facility and hospital programs may not. Those who are not yet Medicare home health care providers, will receive this status once the State Department of Health has performed satisfactory on-site surveys and received approval from the Department of Health and Human Services. New Medicare providers will be expected to assume the responsibility for the major Medicare maximization effort starting on the date of their certification as a Medicare provider

2. Third Party Coverage Generally:

Chapter 647 of the Laws of 1975 had amended subsection ten of Section 162 of the Insurance Law to require that insurers who issue group policies making provision for inpatient hospital care must also provide coverage for home care.

Chapter 895 further amends the Insurance Law to define what home care shall include. In doing so, the applicable features of the Long Term Home Health Care Program are repeated, thereby ensuring that benefits provided under recently issued

policies will be available for insured parties who are found eligible for the LTHHCP

For a more detailed account of what the Insurance Law requires, districts should review the statute itself (162, d. 10). For the maximization of Third Party Resources, the local district should follow the guidelines set forth by this Department in the recently issued 82 ADM-20 and in the Third Party Resource Desk Guide.

M. Priorities

The primary emphasis of the LTHHCP will be placed upon offering services to patients currently occupying acute care beds while awaiting placement in either a skilled nursing or health related facility. There are areas within New York State where many patients are "backed-up", at significantly higher acute care costs, simply because SNF and HRF beds are not available.

It is anticipated that the offering of an alternative option, the LTHHCP, to SNF and HRF-bound patients will channel many of these patients away from institutionalization and allow them to be cared for at home.

Other groups targeted as priorities are persons in the community who become ill or disabled and who are medically eligible to be placed in an institution (SNF or HRF) as well as those persons who are currently in SNF and HRF facilities and who desire to return to their home and are deemed eligible for the program.

The LTHHCP is seen as having its greatest impact on delaying or substituting for the institutionalization of patients through early identification of eligible clients. This "preventive" approach is more clearly seen in the early identification of patients who are supported by family members. Early identification of a patient before service requirements escalate or the patient's condition deteriorates will enhance the preventive potential of LTHHCP services. Supplying support to these patients and families before the families become overburdened will enhance their efforts and increase the likelihood of their continued support. Every effort should be made to determine LTHHCP eligibility when and where patients are routinely assessed or reassessed for changes in level of care or service provision, regardless of what service or which program is currently supplying care.

N. Payment for Assessments and Reassessments

Payment for the initial assessment (via the DMS-1 Home Assessment Abstract or other successors) of a patient to determine appropriateness and extent of services by a LTHHCP shall not be included in any monthly budget. Payment for assessment shall be as follows:

1. Payment for staff participation in discharge planning is included in the current hospital facility Medicaid rate and shall not be paid as a separate service.

2. If the patient is in a hospital or facility and the physician is not on the staff, reimbursement for the initial assessment is included in the physician's visit fee.

3. If a patient is in the community and (a) the assessment takes place in a clinic, reimbursement for the initial assessment is included in the clinic rate for the care provided; (b) the assessment takes place in the home, reimbursement for a physician performed assessment is included in the physician's home visit fee; (c) the assessment takes place in the home, reimbursement for a certified home health agency nurse performed assessment is included in the CHHA home visit fee; (d) the assessment takes place in the physician's office, reimbursement for the initial assessment is included in the physician's office visit fee.

4. Reimbursement for all assessments and reassessments by LTHHCP providers shall be included in the administrative costs of the LTHHCP provider

O. Right to Fair Hearing

Clients are entitled to notice and a fair hearing if any of the following decisions affecting their care under the LTHHCP are, or are to be, taken:

1. their application for LTHHCP services is denied;
2. LTHHCP services are to be discontinued;
3. a change from an SNF level budget to an HRF level budget

The notice shall inform clients of:

1. their rights to a local conference. This conference does not affect their rights to a fair hearing;
2. the fair hearing request process. The hearing must be requested within 60 days from the date of receipt of the notice; if the client desires services to continue pending a fair hearing, the hearing must be requested within 10 days from the date of receipt of the notice;
3. their rights to legal representation;
4. their rights to cross-examine adverse witnesses;
5. their rights to present evidence, documents and/or witnesses in their own behalf.

LDSS's must provide written notification far enough in advance as to afford clients an opportunity to request scheduling of a fair hearing while services are continued at present (former) levels. LDSS's should make an effort to:

1. keep patients well informed as to the kinds of services they are to receive and the dates upon which they can expect certan services;
2. advise clients in a positive manner as to the reasons for changes in services;
3. advise clients of scheduling changes in delivery of services already being received.

V Effective Date

This Administrative Directive will be effective as of January 1, 1983.

Robert C. Osborne
Deputy Commissioner
Division of Medical Assistance

APPENDIX A

Summary of changes made in the revised administrative directive.

Changes required by Chapter 636 of the Laws of 1980:

1. Annualization of the Budget

   Originally the cost of providing Long Term Home Care services could not exceed 75% of the monthly cost of providing HRF or SNF care. As a result of the new legislation, the cost of care can be calculated on a yearly basis, thus ensuring that short term initial costs will not preclude participation for individuals whose care needs would decrease over a longer period. (See pp. 17-18)

2. Alternate Entry Procedures

   The legislation allows the LTHHCPs to admit patients following the completion of an initial assessment rather than requiring the immediate completion of a comprehensive assessment. This more flexible assessment will allow LTHHCPs to provide services to patients who require services immediately. (See Work Flow pp. 7-9)

3. Medical Eligibility for the LTHHCP

   In the previous ADM, the provision of LTHHCP services was limited to patients who were SNF or HRF eligible and who would otherwise require institutional placement. This last requirement resulted in a strict interpretation. All patients who could be cared for in other home care programs (e.g. personal care services) were not considered for the LTHHCP Under the new legislation, the patient need only be medically eligible for SNF or HRF care.

   (N.B. the 75% cap on costs of care and other provisions still remains.)

4. LTHHCP services can be provided to non-Medicaid patients (p. 5)

Administrative Changes

1. Clarification of items included within patient budget determinations (pp. 12-16)

2. Clarification of the following issues: local social services and Long Term Home Health Care Provider Management Roles (pp. 19-20), physician override (p. 6), and Medicare Maximization (p. 20).

3. Reporting Requirements added.

The basic program features remain the same. (See pp. 3-6 for summary)

-a coordinated package of services

-a program available only to patients who are medically eligible for SNF or HRF care;

-a joint DSS/LTHHCP home assessment and development of a summary of services plan prior to DSS authorization;

-75% cap on the cost of providing LTHHCP services;

-case management, 24 hour coverage.

DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT
HOME ASSESSMENT ABSTRACT

REASON FOR PREPARATION

- ☐ ADMISSION TO LTHHCP
- ☐ INITIAL EVALUATION FOR HOME HEALTH AIDE
- ☐ INITIAL EVALUATION FOR PERSONAL CARE
- ☐ REASSESSMENT FROM _____ TO _____
- ☐ LTHHCP ☐ CHHA ☐ PERSONAL CARE
- ☐ OTHER, SPECIFY _____

GENERAL INSTRUCTIONS:

THIS FORM MUST BE COMPLETED FOR ALL LONG TERM HOME HEALTH CARE PROGRAM PATIENTS AND ALL MEDICAID PATIENTS RECEIVING HOME HEALTH AIDE OR PERSONAL CARE SERVICES. PORTIONS AS INDICATED MUST BE COMPLETED BY RESPECTIVE PERSONNEL FOR THE ABOVE MENTIONED PURPOSES. FOR MORE INFORMATION, SEE DETAILED INSTRUCTIONS.

ABBREVIATIONS:
CHHA-CERTIFIED HOME HEALTH AGENCY
LTHHCP-LONG TERM HOME HEALTH CARE PROGRAM
RN-REGISTERED NURSE
SSW-SOCIAL SERVICE WORKER

INSTRUCTION PAGE 1·
TO BE COMPLETED BY RN-PARTS 1,2,3
TO BE COMPLETED BY SSW-PARTS 1,2,3,4,5,6

PATIENT NAME

RESIDENT ADDRESS APT. NO.

CITY STATE ZIP TEL NO.

ADDRESS WHERE PRESENTLY RESIDING TEL NO.

DIRECTIONS TO CURRENT ADDRESS

SOCIAL SERVICES DISTRICT FIELD OFFICE

4. NEXT OF KIN/GUARDIAN

STREET

CITY STATE ZIP

RELATION TEL NO.

3. CURRENT LOCATION/DIAGNOSIS OF PATIENT

- ☐ HOSP ☐ HRF ☐ HOME
- ☐ SNF ☐ DCF ☐ OTHER (SPECIFY)

NAME OF FACILITY/ORGANIZATION

STREET

CITY STATE ZIP TEL NO.

DATE ADMITTED PROJECTED DISCHARGE DATE

DIAGNOSIS

6. NOTIFY IN EMERGENCY
NAME
CITY STATE ZIP

RELATION TEL NO.

PATIENT INFORMATION

5. DATE OF BIRTH _____ AGE _____
LANGUAGE(S) SPOKEN/UNDERSTANDS _____

SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS.
- ☐ MARRIED ☐ SEPARATED
- ☐ SINGLE ☐ DIVORCED
- ☐ WIDOWED ☐ UNKNOWN

LIVING ARRANGEMENTS:
- ☐ ONE FAMILY HOUSE ☐ HOTEL
- ☐ MULTI-FAMILY HOUSE ☐ APT
- ☐ FURNISHED ROOM ☐ BOARDING HOUSE
- ☐ SENIOR CIT HOUSING ☐ IF WALK-UP (# FLIGHTS)
- ☐ OTHER, SPECIFY _____

LIVES WITH: ☐ SPOUSE ☐ ALONE ☐ OTHER _____

SOCIAL SECURITY NO. _____

MEDICARE NO. PART A _____
PART B _____

MEDICAID NO. _____ ☐ PENDING

BLUE CROSS NO. _____

WORKMENS COMP _____

VETERANS CLAIM NO. _____

VETERANS SPOUSE ☐ YES ☐ NO

OTHER (SPECIFY) _____

SOURCE OF INCOME/OTHER BENEFITS
- ☐ SOCIAL SECURITY
- ☐ PUBLIC ASSIST
- ☐ VETERANS BENEFITS
- ☐ PENSION
- ☐ FOOD STAMPS
- ☐ S...d.
- ☐ OTHER (SPECIFY) _____

AMOUNT OF AVAILABLE FUNDS AFTER PAYMENT OF RENT TAXES UTILITIES, ETC. _____

7. To be completed by S S W

OTHERS IN HOME/HOUSEHOLD: Indicate days/hours that these persons will provide care to patient. If none will assist explain in narrative.

	Name	Age	Relationship	Days/hours at home	Days/hours will assist
1.					
2.					
3.					
4.					

8. To be completed by S S W

SIGNIFICANT OTHERS OUTSIDE OF HOME: Indicate days/hours when persons below will provide care to patient.

	Name	Address	Age	Relationship	Days/Hours Assisting
1.					
2.					
3.					
4.					
5.					

9. To be completed by S S W

COMMUNITY SUPPORT Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

	Organization	Type of Service	Presently Receiving	Contact Person	Tel No.
1.					
2.					
3.					
4.					

10. To be completed by S S W and R.N.

PATIENT TRAITS:	Yes	No	? N/A	If you check No, ? N/A, describe
Appears self directed and/or independent				
Seems to make appropriate decisions				
Can recall med routine/recent events				
Participates in planning/treatment program				
Seems to handle crises well				
Accepts Diagnosis				
Motivated to remain at home				

11. To be completed by S S W and R.N. as appropriate.

FAMILY TRAITS:

	Yes	No	?	
a. Is motivated to keep patient home				If no, because
b. Is capable of providing care (physically & (emotionally)				If no, because
c. Will keep patient home if not involved with care				Because
d. Will give care if support services given				How much
e. Requires instruction to provide care				In what—who will give

12. To be completed by R.N.

HOME/Place where care will be provided:	Yes	No.	?	If problem, describe
Neighborhood secure/safe				
Housing adequate in terms of: Space				
Convenient toilet facilities				
Heating adequate and safe				
Cooking facilities & refrigerator				
Laundry facilities				
Tub/shower/hot water				
Elevator				
Telephone accessible & usable				
Is patient mobile in house				
Any discernible hazards (please circle)				Leaky gas, poor wiring, unsafe floors, steps, others (specify)
Construction adequate				
Excess use of alcohol/drugs by patient/ caretaker; smokes carelessly.				
Is patient's safety threatened if alone?				
Pets				

ADDITIONAL ASSESSMENT FACTORS: _____

13. To be completed by R.N.

RECOVERY POTENTIAL ANTICIPATED		COMMENTS
Full recovery	☐	
Recovery with patient managed residual	☐	
Limited recovery managed by others	☐	
Deterioration	☐	

14. To be completed by RN – SSW to complete "D" as appropriate

FOR THE PATIENT TO REMAIN AT HOME – SERVICES REQUIRED

SERVICES REQUIRED	YES	NO	TYPE/FREQ/DUR	WHO WILL PROVIDE AGENCY/FAMILY	AGENCY FREQUENCY
A. Bathing					
Dressing					
Toileting					
Admin. Med.					
Grooming					
Spoon feeding					
Exercise/activity/walking					
Shopping (food/supplies)					
Meal preparation					
Diet Counseling					
Light housekeeping					
Personal laundry/household linens					
Personal/financial errands					
Other					
B. Nursing					
Physical Therapy					
Home Health Aide					
Speech Pathology					
Occupational Therapy					
Personal Care					
Homemaking					
Housekeeping					
Clinic/Physician					
Other 1.					
2.					
C. Ramps outside/inside					
Grab bars/hallways/bathroom					
Commode/special bed/wheelchair					
Cane/walker/crutches					
Self-help device, specify					
Dressings/cath. equipment, etc.					
Bed protector/diapers					
Other					
D. Additional Services (Lab, O_2, medication)					
Telephone reassurance					
Diversion/friendly visitor					
Medical social service/counseling					
Legal/protective services					
Financial management/conservatorship					
Transportation arrangements					
Transportation attendant					
Home delivered meals					
Structural modification					
Other					

15. To be completed by SSW and RN.

DMS Predictor Score _____ Override necessary ☐ Yes ☐ No

Can patients health/safety needs be met through home care now? ☐ Yes ☐ No

If no, give specific reason why not _____

Institutional care required now? ☐ Yes ☐ No If yes, give specific reason why.

Level of institutional care determined by your professional judgment: SNF☐ HRF☐ DCF☐

Can the patient be considered at later time for home care? Yes☐ No☐ N/A☐

16. To be completed by SSW

SUMMARY OF SERVICE REQUIREMENTS

Indicate services required, schedule and charges (allowable charge in area)

Services	Provided By	Hrs./Days/Wk.	Date Effective	Est Dur.	Unit Cost	Payment by MC	MA	Self	Other
Physician									
Nursing									
Home Health Aide									
Physical Therapy									
Speech Pathology									
Resp. Therapy									
Med. Soc. Work									
Nutritional									
Personal Care									
Homemaking									
Housekeeping									
Other (Specify)									
Medical Supplies/Medication 1.									
2.									
3.									
Medical Equipment 1.									
2.									
3.									
Home Delivered Meals									
Transportation									
Additional Services 1.									
2.									
			SUBTOTAL						
Structural Modification									
Other (Specify) 1.									
2.									

SUBTOTAL _____

TOTAL COST _____

17. To be completed by SSW and RN

Person who will relieve in case of emergency

Name	Address	Telephone	Relationship

Narrative: Use this space to describe aspects of the patients care not adequately covered above.

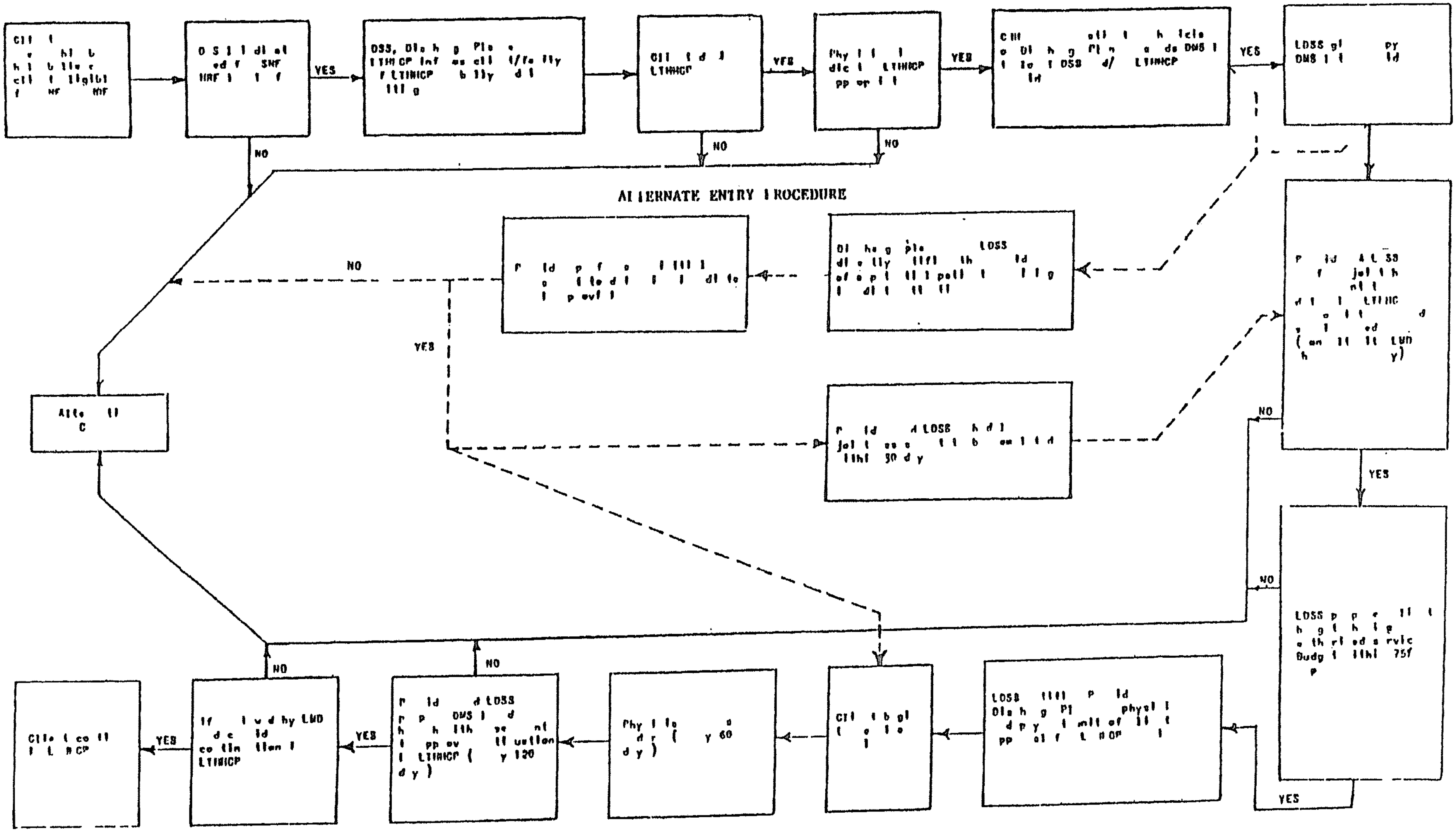
Assessment completed by:

R.N.	Agency
Date Completed	Telephone No.
Local DSS Staff	District
Date Completed	Telephone No.
Supervisor DSS	District
Date	Telephone No.

Authorization to provide services:

Local DSS Commissioner or Designee	Date

CLIENT ENTRY INTO LONG TERM HOME HEALTH CARE PROGRAM



*CHHA (C   d H   H lth Ag   y)

DSS-2057 (10/78)

LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) CHECKLIST

INSTITUTIONALIZED PATIENT

PATIENT'S NAME

HOME ADDRESS

PRESEN LOCATION

Date admitted to present location .....

HOSPITAL NUMBER:

MEDICAID NUMBER:

This form is to be completed by the discharge planner for patients who are *Medicaid recipients* and who have been determined as *requiring SNF or HRF level care* when there is a LTHHCP in the social services district. This form should be completed on *all* patients who meet the above criteria even if it has been determined that home care is not a viable alternative for the patient. The form will be used as an evaluation tool for the LTHHCP When complete, it should be forwarded, together with the DMS-1, to the social services office.

1 Date of DMS-1 completion indicating SNF/HRF level of care .....

DMS-1 Score (Attach form) .....

2 Date ☐ Patient ☐ Family notified verbally and in writing of LTHHCP option .....

☐ Accepted
☐ Rejected

REASON FOR REJECTION

SIGNATURE/TITLE

3 Date LTHHCP option for this patient was discussed with physician .....

PHYSICIAN
☐ Approved
☐ Disapproved

REASON PHYSICIAN DISAPPROVED

NAME OF PHYSICIAN

SIGNATURE/TITLE

If numbers 2 and 3 are affirmative, number 4 MUST be completed.
If either number 2 or 3 are rejections, forward this form and completed DMS-1 to LOCAL Department of Social Services.

4 Date local social services notified of this potential LTHHCP patient .....
(telephone notification is acceptable)

NAME OF LOCAL DSS STAFF NOTIFIED

SIGNATURE/TITLE

5 Date of Patient Discharge

DESTINATION

SIGNATURE/TITLE

COMMENTS ON DISCHARGE

When completed, attach DMS-1 and send both forms to local social services office.

S-3058 10/78)

)NG TERM HOME HEALTH CARE PROGRAM (LTHHCP) CHECKLIST

)TIENT AT HOME

)TIENT'S NAME	MEDICAID NO.

)ME ADDRESS

a. Date of initial contact with LTHHC or CHHA

b. CONTACT (request for service/placement) MADE BY

c. ATTACH COPY OF DMS-1	DATE OF DMS-1	DMS- SCORE

This form is to be completed by the nurse from the LTHHCP or CHHA who is assessing the patient for level of care needs (DMS-1). The form is to be done on *all Medicaid Patients* who have been determined as *requiring SNF or HRF* level of care when there is a LTHHCP in the social services district. It must be completed whenever the DMS-1 indicates SNF or HRF level of care is appropriate even if home care is *not* viewed as a viable alternative. This form will be used as an evaluation tool for the LTHHCP as well as assisting in meeting the requirements for notification to all SNF HRF eligibles of the alternatives in the LTHHC Program.

Date ☐ Patient ☐ Family notified verbally and in writing of LTHHCP option .....

2

REASON FOR REJECTION	SIGNATURE/TITLE
☐ Accepted ☐ Rejected	

Date LTHHCP option for this patient was discussed with physician .....

3

PHYSICIAN	REASON PHYSICIAN DISAPPROVES	NAME OF PHYSICIAN
☐ Approved ☐ Disapproved		SIGNATURE/TITLE

If numbers and are affirmative, number 4 MUST be completed.
If either number 2 or 3 are rejections, forward this form and completed DMS-1 to LOCAL Department of Social Services.

Date local social services notified of this potential LTHHCP patient .....
(telephone notification is acceptable)

4

NAME OF LOCAL DSS STAFF NOTIFIED	SIGNATURE/TITLE

5

Date of completion of Home Assessment Abstract (HAA)	By Registered Nurse .....
	By DSS Caseworker .....

COMMENTS

6

DECISION ON PLACEMENT	DATE

COMMENT	SIGNATURE/TITLE

When completed, attach DMS- and send both forms to local social services office.

NEW YORK STATE DEPARTMENT OF HEALTH

LONG TERM CARE PLACEMENT FORM
MEDICAL ASSESSMENT ABSTRACT

PREDICTOR SCORE

CURRENT PAT. LOCATION

☐ HOSP ☐ DCF
☐ SNF ☐ HOME CARE
☐ HRF ☐ OTHER
SPECIFY

REASON FOR PREPARING FORM

☐ DISCHARGE/TRANSFER TO
☐ ADMISSION FROM
☐ REVIEW FOR PERIOD FROM TO
☐ MEDICAID REVIEW ☐ DEATH
☐ OTHER. SPECIFY

PATIENT NAME LAST FIRST M.I. | STREET CITY STATE ZIP | SEX ☐ MALE ☐ FEMALE

PATIENT NUMBERS

S.S. NO.
MEDICARE NO.
MEDICAID NO.
SOC. SERVICE DIST.
MEDICAL RECORD NO.
ROOM NO.

PATIENT DATES

DATE OF BIRTH AGE
DATE OF LATEST HOSP. STAY
FROM
TO
DATE THIS ADMISSION
RESPONSIBLE PHYSICIAN

PROVIDER INFO

NAME
ADDRESS
MEDICAID NO.
MEDICARE NO.
DOES PATIENT HAVE PRIVATE INSURANCE?
NO☐ YES☐

MEDICAL COVERAGE: PATIENT'S CONDITION AND TREATMENT REQUIRING SKILLED SUPERVISION (ALL ITEMS MUST BE COMPLETED)

1. A. DIAGNOSIS OCCASIONING CURRENT USE OF SERVICES:

PRIMARY
OTHER
OTHER
OTHER

B. NATURE OF SURGERY DATE
C. IF PATIENT HAD CVA/MI SPECIFY DATE
D. ALLERGIES OR SENSITIVITIES, SPECIFY

2. LIST SIGNIFICANT MEDS/INJECTIONS:
(FOR PARENTERAL MEDS ALSO CHECK ITEM 3A)

MED	DOSE	FREQUENCY	ROUTE

3. A. NURSING CARE & THERAPY (SPECIFY DETAILS IN 3D, 3E, OR ATTACHMENT)

	FREQUENCY			SELF CARE		CAN BE TRAINED	
	NONE	DAY SHIFT	NIGHT/EVE SHIFT	YES	NO	YES	NO
PARENTERAL MEDS							
INHALATION TREATMENT							
OXYGEN							
SUCTIONING							
ASEPTIC DRESSING							
LESION IRRIGATION							
CATH/TUBE IRRIGATION							
OSTOMY CARE							
PARENTERAL FLUID							
TUBE FEEDINGS							
BOWEL/BLADDER REHAB							
BEDSORE TREATMENT							
OTHER (DESCRIBE)							

B. INCONTINENT
URINE: OFTEN* ☐ SELDOM** ☐ NEVER ☐ FOLEY ☐
STOOL: OFTEN* ☐ SELDOM** ☐ NEVER ☐

C. DOES PATIENT NEED SPECIAL DIET? NO ☐ YES ☐
IF YES, DESCRIBE

*MORE THAN ONCE A WEEK **ONCE A WEEK OR LESS

3. D. IS THE PATIENT'S CONDITION UNSTABLE SO THAT AN R.N. MUST DETECT/ EVALUATE NEED FOR MODIFICATIONS OF TREATMENT/CARE ON A DAILY BASIS?

NO ■ YES ☐

IF YES, DESCRIBE INSTABILITY AND SPECIFIC NEED FOR NURSING SUPERVISION, VITAL SIGNS RANGES, LAB VALUES, SYMPTOMS, ETC.

E. IS THERE HIGH PROBABILITY THAT COMPLICATIONS WOULD ARISE IN CARING FOR THE PATIENT WITHOUT SKILLED NURSING SUPERVISION OF THE TREATMENT PROGRAM ON A DAILY BASIS?

NO ☐ YES ☐

IF YES, DESCRIBE (a) PATIENT'S CONDITION REQUIRING SKILLED NURSING SUPERVISION (b) THE AGGREGATE OF SERVICES TO BE PLANNED AND MANAGED IN THE TREATMENT PROGRAM. INDICATE SERVICES NEEDED AND POTENTIAL DANGERS OF COMPLICATING CLINICAL FACTORS.

F. CIRCLE THE MINIMUM NUMBER OF DAYS/WEEKS OF COMPLEX SKILLED NURSING SUPERVISION:

REQUIRES	RECEIVES
0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7

PATIENT NAME LAST FIRST M.I. PATIENT SSN MEDICAL RECORD NO. ROOM NO.

4. FUNCTION STATUS	SELF CARE	SOME HELP	TOTAL HELP	CAN NOT	REHAB* POTEN.
WALKS WITH OR W/O AIDS					
TRANSFERRING					
WHEELING					
EATING/FEEDING					
TOILETING					
BATHING					
DRESSING					

5. MENTAL STATUS	NEVER	SOME-TIMES	ALWAYS		REHAB* POTEN.
ALERT					
IMPAIRED JUDGEMENT					
AGITATED (NIGHTTIME)					
HALLUCINATES					
SEVERE DEPRESSION**					
ASSAULTIVE					
ABUSIVE					
RESTRAINT ORDER					
REGRESSIVE (BEHAVIOR)					
WANDERS					
OTHER (SPECIFY)					

6. IMPAIRMENTS	NONE	PARTIAL	TOTAL		REHAB* POTEN.
SIGHT					
HEARING					
SPEECH					
COMMUNICATIONS					
OTHER(CONTACTURES,ETC)					
SPECIFY					

7. SHORT TERM REHAB THERAPY PLAN
(TO BE COMPLETED BY THERAPIST)

A.

DESCRIPTION OF CONDITION (NOT DX) NEEDING INTERVENTION	SHORT TERM PLAN OF TREATMENT AND EVALUATION & PROGRESS IN LAST 2 WEEKS	ACHIEVEMENT DATE

B. CIRCLE MINIMUM NUMBER OF DAYS/WEEK OF SKILLED THERAPY FROM EACH OF THE FOLLOWING:

REQUIRES		RECEIVES
0 1 2 3 4 5 6 7	PT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	OT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	SPEECH	0 1 2 3 4 5 6 7

8. DO THE WRITTEN ORDERS OF THE ATTENDING PHYSICIAN AND PLAN OF CARE DOCUMENT THAT THE ABOVE NURSING AND THERAPY ARE NECESSARY? NO ☐ YES ☐

9. A. SHOULD THE PATIENT BE CONSIDERED FOR ANOTHER LEVEL OF CARE? NO ☐ YES ☐ IF YES: WHEN? _____ WHAT LEVEL? _____

B. AS A PRACTICAL MATTER, COULD PATIENT BE CARED FOR AS AN OUTPATIENT? NO ☐ YES ☐

C. AS A PRACTICAL MATTER, COULD PATIENT BE CARED FOR UNDER HOME CARE? NO ☐ YES ☐
IF YES TO ANY OF ABOVE, ATTACH A DISCHARGE PLAN.

10. SHOULD THE PATIENT/RESIDENT BE MEDICALLY QUALIFIED FOR SNF CARE? COVERED ☐ QUESTIONABLE ☐ NON-COVERED ☐***

11. ADDITIONAL COMMENTS ON PATIENT CARE PLAN/REHAB POTENTIAL: _____

12. I CERTIFY, TO THE BEST OF MY INFORMATION AND BELIEF, THAT THE INFORMATION ON THIS FORM IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

_____ (SIGNATURE OF DESIGNATED R.N. AND TITLE) _____ DATE ASSESS. COMPLETED

TO BE COMPLETED BY U.R. AGENT OR REPRESENTATIVE UPON CONTINUED STAY REVIEW

13. ADDITIONAL INFORMATION BY U.R. REPRESENTATIVE

_____

_____

14. NEXT SCHEDULED REVIEW DATE _____

15. U.R. REPRESENTATIVE: PLACEMENT _____
SIGNATURE _____ DATE _____

16. U.R. PHYSICIAN: PLACEMENT _____
SIGNATURE _____ DATE _____

* CHECK THE BOX CORRESPONDING TO APPROPRIATE CRITERION IF THERE IS A LIKELIHOOD THAT THE PATIENT WILL RESPOND UNDER A COORDINATED PLAN OF RESTORATIVE TREATMENT (INDICATE PLAN IN ITEM 3E OR 11).

** IF PATIENT HAS SEVERE DEPRESSION, PSYCHIATRIC CONSULTATION SHOULD BE OBTAINED.

*** IF CHECKED "NON-COVERED", SNF PLACEMENT CANNOT BE APPROVED BY MEDICAID.

A. ITEMS 1, 2, 3, 4, 5, 6 SHOULD BE COMPLETED BY NURSE.
B. ITEM 7 SHOULD BE COMPLETED BY THERAPIST.
C. ITEMS 8, 9, 10, 11, 12 TO BE COMPLETED IN CONSULTATION WITH THE HEALTH TEAM.

NEW YORK STATE DEPARTMENT OF HEALTH
GUIDELINES FOR COMPLETING THE
LONG TERM CARE PLACEMENT FORM
MEDICAL ASSESSMENT ABSTRACT (DMS-1) FORM *

The DMS-1 (Long Term Care Placement Form) has been developed to assure placement at the appropriate level of care by assisting in the proper assessment of the medical care needs of patients requiring alternate level of care placement.

For ease in identification of items on the DMS-1 form in the following discussion, each item has been denoted by a number as indicated. Therefore, #1 refers to the item 1 on the inset diagram – (Predictor Score). These numbers appear only in these guidelines and do not appear on the DMS-1 form.

Box #1 Predictor Score – 

Upon completion of the medical assessment of the DMS-1 form, the correct assignment of numerical weights should be assigned to each item checked from the master score sheet attached. The total of these scores should be placed in Box #1.

#2 Current Patient Location
The appropriate box should be checked to accurately indicate the patient's current location. For example, if the patient is presently in an acute care setting, the box "Hospital" should be checked. "Other" should be used if no other category listed applies such as a hotel, private boarding house, etc., in which the patient has no facilities other than sleeping arrangements.

#3 Reason for Preparing Form
[] Discharge/transfer to _____
[] Admission from _____
[] Review for period from _____ to _____
[] Medicaid Review _____ [] Death
[] Other – Specify _____

#3- The DMS-1 is a multi-purpose form. Its exact use must be indicated by checking the appropriate box to the left of the alternative given.
If the patient has been admitted to a facility from a hospital or another facility, a check mark should be put in the box next to "Admission from _____". The complete name of the facility the patient was admitted from should be written in the blank space to the right.

*** These Guidelines have been retyped from New York State Department of Health Hospital Memorandum 77-13 so they could be more easily read. Clarifications issued in 7/03 and 2/04 specific to the LTHHCP have been included in the instructions (in bold type). The references cited throughout the instructions referring to Appendix B are not included as they no longer apply.**

If the patient is in a long term care facility and is to be discharged with no follow-up in another setting, the box to the left of "Discharge/transfer to _____ " should be marked with the patient's destination in the blank space to the right and only the identifying information needs to be completed. If the patient is to be transferred from one facility to another, the name of the institution to which the patient should be transferred should then be given in the space to the right.

If the patient is to be reviewed for Medicaid or for continued stay, then the appropriate box should be checked. For the "Continued Stay Review" be sure to include the dates in the space to the right.

If the patient for whom a DMS-I has been previously prepared dies, the box to the left of "Death" should be checked and only items 4-21 need to be completed.

#4	#5	#6
Patient Name Last First M.I.	Street City State Zip	Sex [] Male [] Female

Patient Numbers	Patient Dates	Provider Info
S.S. No._____#7_____	Date of Birth__#13___ Age_____	Name_____17_____
Medicare No._____#8_____	Date Latest Hosp. Stay	Address_____18_____
Medicaid No._____#9_____	From_____#14_____	Medicaid No._____19_____
Soc. Service Dist._____#10_____	To_____	Medicare No._____20_____
Medical Record No.____#11_____	Date This Admission_____15____	Does Patient Have Private Insurance?
Room No._____#12_____	Responsible Physcian____16_____	[] No [] Yes_____21_____

Item #4. The patient's name with the last name, first name, and middle initial given in that order.

#5. The patient's home address including the street, city, state, and zip code.

#6. The patient's sex.

#7. The patient's social security number.

#8. The patient's Medicare number.

#9. The patient's Medicaid number.

#10. The social service district is the county in which the patient resides.

#11. The Medical record number for the patient's record.

#12. The patient's room number in the facility originating this form.

#13. The date of birth of the patient and the patient's age.

#14. The dates of the most recent hospital stay.

#15. The date of admission to the facility originating this form.

#16. The physician presently in charge of the patient's treatment plan.

#17. Refers to the facility originating this form.

#18. The address of the facility originating this form.

#19. The provider's Medicaid number.

#20. The provider's Medicare number.

#21. If private insurance is available, indicate what policy.

Items #4-21 identify the patient, provider, physician and social service district involved with the patient. Some of the information (primarily # 8, 13, 14, & 15) are important clues in determining technical eligibility under Title XVIII - Medicare. Age 65 or over (#13) is an important factor and many persons over the age of 65 are eligible to receive SNF Part A and possibly Part B benefits. Other persons who may be receiving Medicare benefits include these persons who are entitled to disability benefits for not less than 24 months consecutively are also entitled to Medicare though under the age of 65. Fully or currently insured workers or their dependents with end stage kidney disease are deemed disabled for purposes of Medicare coverage provided that hemodialysis or kidney transplantation are needed. The coverage begins the 3rd month after the month of onsite of the condition and continues through the 12th month after the month in which the patient has a successful

transplant or dialysis ends. For further clarification, see regulations 405.101 - 405-105 in the Code of Federal Regulations.
Exploring for private health insurance is an important role of the discharge planner. There may be untapped resources such as Veteran's Benefits, Workman's Compensation or Health Plans by private insurance companies which have not been previously recognized as resources for the patient's care.

The second section of the DMS-1 form is used to document the patient's current medical condition and treatment requiring skilled supervision. All items in this section must be completed.

#22: MEDICAL COVERAGE : Patient's condition and treatment requiring skilled supervision. (All items must be completed)

#22	A. Diagnosis Occasioning Current Use of Services:
	Primary_____**A**_____
	Other_____**B**_____
	Other_____B_____
	Other_____B_____
B.	Nature of Surgery (if any)_____**23**_____ Date _____**24**_____
C.	If patient had CVA/MI specify _____**25**_____ Date__**26**____
D.	Allergies or sensitivities, specify _____**27**_____

#22 - refers to the diagnoses for which the patient is being treated.

#22A. - the primary diagnosis ..... that Disease (Syndrome or Condition) for which the patient was or is being treated in the hospital, the primary diagnosis is the diagnosis most responsible for the patient's need for medical care in the long term care facility. It may not be the actual admitting diagnosis but rather the present diagnosis which is the focus of the Medical Care treatment plan. For example, a patient who is admitted to the hospital with gangrene of the left foot and later had a below the knee amputation would have a primary diagnosis (**22A**) of BK amputation of left leg. Other diagnoses (**22B**) refer to those conditions which also continue to exist. They may have been present for some time and perhaps did not directly cause the hospitalization although they may have contributed to it or may influence the treatment plan. In the above example, the other diagnoses might include diabetes mellitus, arteriosclerosis, etc. The patient might also have other diagnoses for which he is receiving regular treatment but because of the present illness, the treatment program must be modified in some way to meet the present situation. For example, the patient may be receiving monthly injections of Vitamin B12 for his pernicious anemia. This must continue as he is no longer able to go to the physician's office and other plans to receive the injection must be made.

#23- as the patient did have surgery, this item should read "BK amputation left leg" and the date of this surgery should be in **#24**. It is also important to note if the patient has had either a CVA or an MI (or both) in the past and the approximate date when this (these) events occurred as they will most likely affect the treatment care program **(#25)**. Items **22A and B, 23, 25, and 27** should be reflected in the treatment care program, and be evident in the patient's medical record. **Note:** Diagnoses occasioning current use of services must be pertinent and timely. Do not report items which have occurred a long time ago and do not affect the need for skilled nursing today.

#28 - List Significant Meds/Injections

Medication	Dose	Route	Frequency

All significant medications (other than sedatives, laxatives, stool softeners, across the counter or medicine chest items) should be listed in **#28**. The information should include the name of the medication, the amount ordered, the route of administration and how frequently it is given to the patient. This information must have been

ordered by the patient's physician and be so documented on the patient's medical record. In the area of medications, Medicare views intravenous and intramuscular administration of medication as a skilled nursing service. The administration of an injection which can be self-administered by the patient is considered a skilled nursing service if the patient is in the training phases of self-administration and requires teaching and supervision by skilled nursing personnel or if the patient's condition because of medical complications requires skilled performance, supervision, or observation. The same is true of medications administered by any other route which normally is self-administrated. If parenteral medications are given, they should be included here and indicated in **Item #29** under Nursing Care and Therapy.

Note: Fecal softeners, laxatives, sleeping pills, should not be included since they are not significant for purposes of SNF coverage in a stable patient or one who needs only custodial care. Indicate only those medications which require skilled nursing to administer or to evaluate the effects. Medications and diagnoses identified should be consistent with one another.

Item #29

3. A. Nursing Care & Therapy (Specify details in 3D, 3E or attachment)	**Frequency**			**Self Care**		**Can Be Trained**	
	NONE	DAY SHIFT	NIGHT/ EVE. SHIFT	YES	NO	YES	NO
PARENTERAL MEDS							
INHALATION TREATMENT							
OXYGEN							
SUCTIONING							
ASEPTIC DRESSING							
LESION IRRIGATION							
CATH/TUBE IRRIGATION							
OSTOMY CARE							
PARENTERAL FLUIDS							
TUBE FEEDINGS							
BOWEL/BLADDER REHAB							
BEDSORE TREATMENT							
OTHER (DESCRIBE)							

#29 delineates those nursing care services the patient receives. The importance of the frequency, self-care and can be trained areas must reflect the medical care plan, physician's orders, progress notes and nursing notes of the patient's medical record. Each item must be checked. If the patient is not receiving a particular therapy or nursing care item, the column none should be checked. The columns Self Care and Can be Trained, should be used only when the Frequency column indicates the item is being given to the patient on either the Day Shift and/or the Night/Evening Shift. Specific services which are delineated as skilled nursing services, as cited in (FR Regulation Sec. 405.127 is as follows.) (See ATTACHMENT B.)
The specific details of the nursing treatment including, for example, the size and location of the decubitus ulcer and treatment regimen and progress should be given in 3D and E, or 11 on the DMS-1 or in an attachment.

The treatments listed in Section 3A. should only be checked and scored if the LTHHCP provides the treatment. If the treatments listed are self administered, then the frequency should be checked "none". Self administered means that the recipient (or his/her caregiver) gives him or her self the injection, oxygen, nebulizer or other treatment. If the LTHHCP is providing the treatment, but training the recipient in self administration, then the "self care" and "can be trained" boxes should be appropriately checked, in addition to the frequency. Please note: The use of an inhaler by a recipient for self administration is not considered inhalation treatment.

#30

B. Incontinent			
Urine: Often*[]	Seldom**[]	Never[]	Foley []
Stool: Often* []	Seldom**[]	Never[]	

* more than once a week ** once a week or less

#30 - The patient's ability to control urinary and bowel excretion is another indication of the patient's condition and nursing needs. As indicated, "often" implies that the patient is unable to control excretory function more frequently than once a week while "seldom" implies once a week or less frequently. If the patient is incontinent, is a Bowel and Bladder rehabilitation program included in the nursing care plan? If so, is this item checked in #29? Be sure to describe the details of the plan of care in 3D, E, or 11 of the DMS-1 including the goals of the program, the patient's response to the plan and when achievement of goals is anticipated. If the patient has a Foley Catheter, is there an irrigation to be checked in #29? How frequent are the catheter changes for comment in 3D, E, or 11?

If the recipient is scored as seldom or often incontinent, according to the instructions for Section 3B, there should be a corresponding strategy in the care plan to address the functional and health issues resulting from the incontinence.

#31. C. Does Patient Need Special Diet? [] No []Yes
If Yes, Describe _____
_____

#31 - The diet the patient needs may make a difference in the alternate care facility selected. Any SNF should provide any prescribed diet. Certain categories of diets may be obtained in an HRF (mechanical soft, low sodium, modified diabetic).

#32

3.D	Is the patient's condition unstable so that an R.N. must detect/evaluate need for modification of treatment/care on a DAILY basis?
	NO [ ] YES [ ]
	If yes, describe instability and specific need for nursing supervision, vital signs ranges, lab values, symptoms, etc.

#32- If "no" is checked, it is assumed that the patient's condition is stable and that skilled nursing care on a daily basis is not necessary. This does not necessarily disqualify a patient from receiving Medicare post hospital coverage (SNF Part A) as long as "yes" is checked for 3E. However, if both are "no", the patient most likely does not require SNF level of nursing care

If "yes" is checked, the comments should be pertinent to the diagnosis, medications and treatments given. The dimensions of the instability should be stated precisely with the inclusion of any modifications to be made because of the instability. For example, if the patient's Diabetes Mellitus has not stabilized and modifications of Insulin type and doses which are the fractional urines should be stated along with the changes in medication, diet and/or activity allowances that may be required.
Regulations Section 405.127 (c) (1) (ii) of the 20 Code of Federal Regulations (CFR) is in APPENDIX B and addresses this area.

#33

B. Is there high probability that complications would arise in caring for the patient without skilled nursing supervision of the treatment program on a daily basis? NO[ ] YES [ ] If yes, describe (a) patient's condition requiring skilled nursing supervision (b) the aggregate of services to be planned and managed in the treatment program. Indicate services needed and potential dangers of complicating clinical factors.

#33- If "no" is checked, it is assumed that complications would be unlikely if the patient's treatment program was not supervised by skilled nursing personnel on a daily basis.

If "yes" is checked, the comments should be directed to the complications which might occur if skilled supervision was not available even though the services given may not require a skilled nurse to perform them. For example, the Diabetic patient who requires fractional urines, special diet, skin care and foot care may have these services performed by unskilled personnel. However, the planning, the effect and the results must be supervised by skilled nursing personnel to avoid hyper or hypoglycemia, gangrene of extremities, prevention of injury or immediate attention to incurred injury to prevent infection. The skilled service is directed to the interrelationships of the patient's conditions and effects each part has on the other. Regulations Section 405.127 (c) (1) (i) the 20 Code of Federal Regulations addresses this area and can be found in APPENDIX B.

#34

F.	Circle the minimum number of days/week of complex skilled nursing supervision:	
	Requires	**Receives**
	01234567	01234567

#34-If the patient requires 7 days of skilled nursing care and/or supervision, the number "7" should be circled. If he receives 7 days of skilled nursing care/supervision the number 7 should be circled under the column RECEIVES. Regulation Section 405.128 of the 20 CFR addresses this area and can be found in APPENDIX B.

Page 2 of the DMS-1:

#35

Patient Name Last	First	M.I.	Patient S.S. No.	Medical Record No.	Room No.

#35- serves to identify the patient and should be the same as the front page of the DMS-1. It is important that these boxes be completed as xerox copies made of the DMS-1 may fail to identify the correct patient if these boxes on the 2nd page are not completed.

#39

4. FUNCTION STATUS	SELF CARE	SOME HELP	TOTAL HELP	CANNOT
WALKS WITH OR W/O AIDE				
TRANSFERRING				
WHEELING				
EATING/FEEDING				
TOILETING				
BATHING				
DRESSING				

#39 – Further describes the patient's condition and functional status and will help to support the decision of the nurse in determining the level of care needed by the patient. The Functional Status reflects the patient's custodial care requirements as they are assessed on the day the form is completed. The "cannot" column refers to not being physically able to walk, etc., rather to "not applicable for this patient." The definitions and parameters found in APPENDIX A should be used when checking the box.

The category "some help" should only be checked if the assistance of another person is needed. If the recipient uses medical equipment (cane, walker or other adaptive devices), but performs the ADL without the assistance of another person, then the recipient should be scored as independent.

#40

5. MENTAL STATUS	NEVER	SOMETIMES	ALWAYS
ALERT			
IMPAIRED JUDGMENT			
AGITATED (NIGHTIME)			
HALLUCINATES			
SEVERE DEPRESSION			
ASSAULTIVE			
ABUSIVE			
RESTRAINT ORDER			
REGRESSIVE BEHAVIOR			
WANDERS			
OTHER (SPECIFY)			

#40 - The patient's Mental Status should be marked according to the definitions given for these items in APPENDIX A. If the total score in this box is high or if the patient is severely depressed, wanders, is assaultive or abusive a DMH-103 or a Psychiatric consultation may be needed to determine the appropriate placement for the patient and/or a treatment program to manage the problem may be needed.

If the behaviors listed in the mental status section are observed in the recipient, they should only be scored if the behavior occurs frequently enough to be considered when planning care. Intervention strategies/services should be clearly identifiable on the care plan. Impaired judgment is described in the instructions as "a mental state marked by the mingling of ideas with consequent disturbance of comprehension and understanding and leading to bewilderment, inaccurate or unwise decision making, and unsafe self direction." LTHHCP recipients who refuse services, or who have behaviors that are unhealthy (e.g. smoking), AND who understand the consequences of their behaviors/decisions, would not be considered to have impaired judgment. Individuals have a right to make choices about care and lifestyles.

#41

6. IMPAIRMENTS	NONE	PARTIAL	TOTAL
SIGHT			
HEARING			
SPEECH			
COMMUNICATIONS			
OTHER (Contracture, etc.)			

#41 - The Definitions and parameters of IMPAIRMENTS can be found in APPENDIX A.

#39, 40, and 41 describe the patient's functional level and will help to support the decision determining the level of care necessary for the patient. These functional levels should be reflected in the total plan of care in Items 3D, and 3E. For example, the patient with an Organic Brain Syndrome may require Some or Total Help in many other areas in 39, 40, 41, and without this help, may develop decubiti, malnutrition, etc. The patient might also require reality orientation and close supervision of the total care plan.

#42

7. **SHORT TERM** Rehab Therapy Plan
(To Be Completed By Therapist)

a. Description of Condition Needing Intervention (NOT DX)	Short Term Plan of Treatment and Evaluation & Progress in last 2 weeks	Achievement Date

b. Circle number of days/week of skilled therapy from each of the following:

Requires		Receives
0 1 2 3 4 5 6 7	PT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	OT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	Speech	0 1 2 3 4 5 6 7

#42 - Items 7a and 7b should be completed by the Therapist(s) providing the service(s) if it is being provided. The current plan or treatment and evaluation should refer to short term stage of plan and should be very specific, not general. The achievement date should refer to date projected or anticipated when the short term plans will be accomplished. An achievement date years into the future should not be considered within this placement time-span. The therapy plan should tie-in to the nursing care in 3D and E, if possible to show continuity.

Patients requiring less intense and/or frequent therapy may receive such therapy in an HRF if institutional placement is indicated for the patient.
20 CFR Regulation Section 405.128 in APPENDIX B defines skilled rehabilitation services which must be required and provided on a "daily basis."

Physical therapy, occupational therapy or speech therapy should be scored if the therapy is skilled, rehabilitative therapy provided on a short term basis to improve functioning. Recipients who receive a therapy evaluation only or may need long term maintenance therapy should also be scored.

#44

8. Do the written orders and plan of care of the attending physician document that the above Nursing and Therapy are necessary? No[ ] Yes [ ]

#44 - Calls for the reaffirmation that the medical record and physician orders indicate that the Nursing Care and Rehabilitation Therapy plans are being carried out under the physician's overall orders and treatment plans. A "no" answer in this box would raise serious doubt about the validity of the patient's care, or that the care given is medically necessary and would automatically disqualify the patient from SNF Part A Benefit coverage.

#45

9. A. Should the patient be considered for another level of care:	No[ ]	Yes [ ]
B. As a practical matter, could patient be cared for as an outpatient ?	No[ ]	Yes [ ]
C. As a practical matter, could patient be cared for under home care?	No[ ]	Yes [ ]
If yes to any of above, attach a DISCHARGE PLAN.		

#45 - If 9A. is checked "yes", the patient should be evaluated for the correct level and date for transfer. Items (9B) and (9C) refer to the practical matter of outpatient care or Home care. "Practical" refers to the availability of the services, the patient's ability to leave his home to seek services or the suitability of the home setting in relation to needs and available services. If "yes" is answered in 9C above, a discharge plan, including the need for care, who will provide the care, and when it is available, should be attached to the DMS-1.

> **Note:** the phrase "as practical matter" in items 9B and 9C referring to outpatient or home care means that the home care or outpatient treatment is either not cost-effective, (e.g., the patient would have to be transported by ambulance over a long distance) or that it is medically harmful to the patient. It does not mean that outpatient facilities or a home setting is not available.

#46

10. Should the patient/resident be medically qualified for SNF care? Covered [] Questionable [] Non-Covered []

#46 - This indicates that, in the best judgment of the Health Team, the patient meets the necessary requirements for SNF placement. An indication of "Not Covered" implies that the patient does not require SNF level of care and that he is not eligible to receive Medicaid benefits for SNF level of care

#47

11. Additional comments on patient care plan/rehab potential:_____

#47 - Any additional comments or explanations can be put in #47. These comments should further clarify the patient's medical situation or condition and describe Nursing Plan items in addition to those in 3A, D, E.

#48

12. I certify, to the best of my information and belief, that the information on this form is a true abstract of the patient's condition and medical record. _____ _____ (Signature of Designated RN and Title) Date

#48 - Is self-explanatory as a documentation of the veracity of the information for which the designated RN has taken the responsibility to provide. It should be based upon Medical, Nursing, and Therapy Records of the patient.

#49 TO BE COMPLETED BY U.R. AGENT OR REPRESENTATIVE UPON CONTINUED STAY REVIEW

13. Additional Information by U.R. Representative _____	15. U.R. Representative: Placement _____ Signature_____ Date_____
14. Next Scheduled Review Date _____	16.U.R. Physician Placement_____ Signature_____ Date _____

#49- designed for use primarily in an SNF or HRF, i.e., the Utilization Review Process for the 30-60-90 and thereafter 90 day reviews of the SNF patient or the 6th month review for the HRF patient. This should contain any other information that the on-physician UR representative may have to support the level of care placement assigned. The UR physician, following review of the form, should then place his assessment of the patient's level of care needs followed by his signature and the date of his review. The date of the next scheduled CSR should be placed under 14.

If the UR committee, including at least one physician, decides that the patient no longer requires the level of care given in the facility, notification is sent to the patient's physician. An opportunity to clarify or present further information is given to the patient's physician. If this additional information does not meet the continued stay criteria as determined by two physicians, the two physicians suggest the proper level of care placement and sign their names in #49.

Notes: Items 13-16 - Date included in Item 13 through 16 of the form is administrative in nature reflecting UR Committee processing continued stay reviews. This information need not be completed when the LTC placement form is used to support specifications for medical coverage.

Notes:

a. Items 1, 2, 3, 4, 5, & 6 should be completed by R.N.

b. Item 7 should be completed by Therapist(s).

c. Items 8-12 should be completed in consultation with the Health Team.

d. If Item 10 is checked "non-covered", request for SNF placement cannot be approved by Medicaid.

APPENDIX A

DEFINITIONS

Item 29 (3A)

Parenteral Medications:	Any medication given by subcutaneous, intramuscular, intradermal, intrasternal and intravenous route.
Inhalation Therapy:	The administration and/or teaching of techniques or use of equipment to increase pulmonary capacity, liquify secretions, and/or facilitate the exchange of gases at the alveolir level.
Oxygen:	The administration of Oxygen by any method.
Suctioning:	The use of suction equipment in any body cavity using clean or aseptic technique as appropriate.
Aseptic Dressing:	The application of a sterile dressing using aseptic technique. This also includes the application of medicated ointments, creams, sprays or solutions under sterile conditions to an open lesion.
Lesion Irrigation:	The use of intermittent or continuous sterile or clean moist compresses or soaks, insertion of catheters or tubing into an open lesion for removal of secretions or instillation of medication or debridement of necrotic material.
Cath/Tube Irrigation:	Insertion of a catheter into the urinary bladder and the insertion of fluid through the catheter for the purpose of cleansing or insertion of medication into the urinary bladder using aseptic technique.
Ostomy Care:	The care of a colostomy, ileostomy, ureterostomy, tracheostomy, gastrostomy, or any such opening including the care of the surrounding skin, cleansing and observation of the stoma for patency, and the use of specialized equipment necessary to the maintenance of the "ostomy".
Parenteral Fluids:	The use of the intravenous of subcutaneous route for the administration of fluids used to maintain fluid and electrolyte balance and/or nutrition.
Tube Feedings:	The use of a nasogastric (including the insertion of) gastrostomy or jejunostomy tube for insertion of fluids for hydration, nutrition and medication.
Bowel/Bladder Rehab:	A planned program to gain or regain optimum bowel and bladder function.
Bedsore Treatment:	A planned program to treat decubiti including regular periods for turning, application of medication and/or the use of special equipment.

ITEM 39 FUNCTION STATUS

This refers to the ability of the person to carry out necessary activities of daily living and his degree of need for human assistance.

(a) Walks With Or Without Mechanical Aids:

Independent- Walks with or without equipment or devices, either worn or not, but without the assistance of another person.

Some Help- Walks with necessary assistance of another person.

Total Help- Does not walk except with continuous physical support.

Cannot- Is unable to walk even with assistance.

(b) Transferring:

This describes the process of moving horizontally and/or vertically between the bed, chair, wheelchair and/or stretcher.

Independent- Means the patient receives no assistance or supervision from another person.

Some Help- Includes guarding, guiding, protecting or supervising the patient in the process of transferring.

Total Help- Means the patient is lifted out of bed, chair, etc. by another person or persons and does not participate in the process.

Cannot- Is bedfast and may not be transferred.

(c) Wheeling:

The process of moving about by means of any device equipped with wheels.

Independent- Means the patient receives no assistance or supervision from another person and is mobile independently in using the wheelchair.

Some Help- Means another person helps the patient in getting through doorways, locking or unlocking the brakes, getting up and down ramps.

Total Help- Means the patient is transported in a wheelchair but does not propel or guide it. (Patient may wheel a few feet within room or an activity area but this alone does not constitute wheeling.)

Cannot- May sit in chair but is incapable of any maneuvering it.

(d) Eating/Feeding:

Is the process of getting food from the receptacle into the body.

Independent- Means the patient does not receive assistance from another person. He cuts food, butters bread, pours beverages and conveys food to mouth.

Some Help- Means another person helps the patient in cutting food, opening cartons, pouring liquids.

Total Help- Means the patient is spoon-fed; patient does not bring food to his mouth.

(e) Toileting:

Refers to getting to and from the toilet room, transferring on and off the toilet, cleansing self after elimination and adjusting clothes.

Independent- Means the patient receives no assistance or supervision from another person.

Some Help- Means the patient receives assistance from another person or persons in getting to and from the toilet room, transferring on and off the toilet seat, adjustment of clothes.

Total Help- Means patient uses other means such as urinal, bedpan, or commode.

(f) Bathing:

Describes the process of washing the body or body parts, including getting to or obtaining the bathing water and/or equipment.

Independent- Means the patient receives no assistance or supervision from another person.

Some Help- Means the patient receives help from another person in such ways as filling the tub, towel drying, bringing water to him, assistance in washing or helping patient in and out of tub.

Total Help- Means patient is bathed by another person.

(g) Dressing:

Describes the process of putting on, fastening and taking off all items of clothing, braces, and artificial limbs worn daily by the person; and obtaining and replacing these items from their storage area in the immediate environment.

Independent- Means the patient receives no assistance or supervision from another person.

Some Help- Means another person helps the patient in such things as obtaining the clothing, fastening hooks, buttons, zippers, putting on clothes, putting braces or artificial limbs on.

Total Help- Means the patient is completely dressed by another person.

ITEM 40 MENTAL STATUS

The characteristics are used in their usual dictionary meaning. The degrees indicated should reflect observation of patient's actions rather than personality characteristics.

Always- Occurs enough of the time, i.e., more than once a week, to constitute a regular pattern.

Sometimes- Occurs frequently less than once a week, enough as to need to be taken into consideration when planning care.

Never- Never or almost never.

(a) Alert:

This describes the patient who is able to communicate and provide feed back. Is watchful, able to perceive and react.

(b) Impaired Judgment:

This describes a mental state marked by the mingling of ideas with consequent disturbance of comprehension and understanding and leading to bewilderment, inaccurate or unwise decision making, and unsafe self direction.

(c) Agitated (nighttime):

This refers to the increased activity, restlessness, anxiety, fear and tension that occurs in some persons during the night leading to excited or disturbing behavior.

(d) Hallucinates:

This describes the activity where sense perception is not based upon objective reality.

(e) Severe Depression:

Refers to that abnormal behavior in which the patient remains withdrawn without cause; disinterested in surroundings and in self; refuses to eat or participate in social events and/or speaks of self destructions or makes suicidal attempts.

(f) Assaultive:

This refers to the act or attempt of physical violence upon another person.

(g) Abusive:

This refers to verbal attack of another person.

(h) Restraint Order:

Restraints are defined as physical articles attached to or put about the person to prevent freedom of motion, and usually requiring a physician's order and responsible supervision in their use. Bedside rails and geriatric chairs are not considered restraints in this sense.

(i) Recessive Behavior Signs:

Signs of regressive behavior may occur transiently in persons who are ordinarily stable in a closely supervised setting but who are unable to cope in a less supportive setting, or under stress or threat of change. Such regressive behavior signs include: onset or resumption of incontinence; refusal to eat or feed self; refusal to come out of room or withdrawal from others; attempts to appear sick with assumed nausea or vomiting; developing behavior changes as with agitation or belligerence.

(j) Wanders:

Leaves area boundaries with no particular plan or destination in mind and with no concern for the hazards within the environment (weather, adequate clothing, dangerous terrain, etc.).

ITEM 41 IMPAIRMENTS

(a) Sight

None - Has adequate visual acuity to see in the distance and the near vision to do close work with or without glasses.

Partial - Can perceive hazards in the environment with or without glasses but has sufficient loss of visual acuity and/or peripheral vision to reduce distance and near vision to a minimum.

Total - Visual acuity with glasses is less than 20/200.

(b) Hearing

None - Can hear the normal spoken voice with or without hearing aid. Can discriminate and identify sounds and voices in a group setting.

Partial - Can hear the normal spoken voice with the assistance of a hearing aid but is unable to identify sounds, direction of sound or discriminate voices in a group setting with a hearing aid. May require 2 hearing aids.

Total - Unable to hear and/or discriminate sounds even with the assistance of a hearing aid.

(c) Speech

None - Can speak clearly, distinctly and be understood by others who speak the same language.

Partial - May have some speech defect or indistinction of speech but can get verbal messages across to others most of the time.

Total - Is unable to speak clearly, distinctly, or not at all.

(d) Communication

None - Can send and receive messages verbally, or in writing appropriately or in non-verbal ways.

Partial - Can perceive and act upon messages received but has some problems expressing self verbally in writing appropriately or in non-verbal ways.

Total - Is unable to receive or relay messages either verbally or in writing or in non-verbal ways.