Michigan Department of Health and Human Services
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Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

February 21, 2018

<Provider Name>
<Provider Address 1>
<Provider Address 2>
<Provider City> <State> <zipcode5-zipcode4>

Dear Medicaid Provider:

RE: Field Definition Guidelines for the Medicaid Nursing Facility Level of Care Determination (LOCD) tool.

This letter provides supplemental information (see Attachment A) regarding the application of the Field Definition Guidelines for the Medicaid Nursing Facility LOCD tool. LOCD policies are located in the Michigan Medicaid Provider Manual, in the chapters for Nursing Facility Coverage, the MI Choice program, the Program of All-inclusive Care for the Elderly (PACE) and the MI Health Link program.

The Medicaid Provider Manual can be found at www.michigan.gov/medicaidproviders under Policy, Letters, and Forms. The LOCD Field Definition Guidelines can be found at www.michigan.gov/medicaidproviders under the Resources tab by clicking the Michigan Medicaid Nursing Facility Level of Care Determination link.

This guidance addresses questions from providers, beneficiaries and other stakeholders. Therefore, not all doors or criteria are addressed. MDHHS developed this guidance to facilitate accurate and consistent determinations of individuals' medical and functional eligibility for long-term care services. The guidance also addresses documentation providers must retain in beneficiary or applicant records to support their determinations.

This guidance does not change current LOCD policy, including the Field Definition Guidelines. All of the LOCD policies remain in effect. This guidance only adds clarification to the existing Field Definition Guidelines.

General guidance on documentation:

- The documentation must include the most recent assessments; the Minimum Data Set (MDS), the iHC or the relevant PACE and MI Health Link assessments. The scoring and comments must clearly support the LOCD scoring.

- The plan of care must show how services support the beneficiary's functioning. This includes paid services and unpaid, informal supports. This also includes those services provided to all beneficiaries in a program, such as MI Choice supports coordination or PACE day programs, especially when these services address needs identified in the LOCD scoring.

- All programs are required to conduct a reassessment if there is a significant change of condition, which includes conducting a LOCD to reassess functional eligibility.

Questions about the level of care determination tool or process should be sent to L. Alisyn Daniel-Crawford at daniell@michigan.gov.

Sincerely,

Kathy Stiffler, Acting Director
Medical Services Administration

Enclosure

MDHHS Nursing Facility Level of Care Determination
Field Definition Guidelines Supplement

LOCD Field Definition Guidelines	Supplemental Guidance
Door 1: Activities of Daily Living	
Limited assistance	Includes physical guidance to ensure the beneficiary's safety during non-weight-bearing activities.
Extensive assistance	Defined as weight-bearing support by a provider. It does not include assistive equipment, such as canes or walkers.
	Documentation: The documentation must support how the assessor identified the functional needs, e.g. by beneficiary demonstration, beneficiary, family or provider report. An example of using a family member's report of the beneficiary's rising from a chair: ***Assessor****:* "Tell me how Mrs. L gets up from the chair. Once she is on the chair, how does she move from a sitting to a standing position?" ***Family member****:* "She can move about by herself, but I help her to grab the side rails as she gets up." ***Assessor****:* "Do you give her verbal instructions or does this involve physical help?" ***Family member****:* "Most of the time I just remind her to grab the side rails of the chair when she gets up. If she doesn't, she might fall. But once I tell her how to do things, she can do it herself." ***Assessor****:* "So, how do you help as she actually rises from the chair?" ***Family member****:* "She can help herself by grabbing onto the rail. I tell her what to do. There are times each day when I hold her arm to steady her in getting up." ***Assessor***: "How many days during the three days did you give this type of help? ***Family member*****:** "Every day. For Transfer, Mrs. L would receive an ADL Self-Performance Code of "4" (Extensive Assistance). (iHC Assessment Manual, Section P, Activities of Daily Living (ADL) Self-performance accessible on COMPASS)

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Door 2: Cognitive Performance	
Short-term memory, decision-making and making self-understood	**Documentation for all Door 2 categories:** The documentation must provide specific examples that support the LOCD scoring. A diagnosis alone is not sufficient documentation. Secondary cognitive tests may be used but are not necessary unless specifically required by a long-term care program. When used, the descriptive content of the secondary cognitive test must support the LOCD scores. Document when services assist the beneficiary with a memory task. These should be specific services implemented for the individual beneficiary based upon a history of problems or other factors. This may include conditions where routine services are necessary to prevent failure, e.g. meal routines guided by providers, medication set-up.
Door 3: Physician Involvement	
Physician visits and physician order changes	**Documentation:** On-going eligibility for this door must be monitored during beneficiary contacts according to the schedule required by the program. Nursing facilities have daily contacts with beneficiaries; MI Choice, PACE and MI Health Link require monthly contacts. If there is no significant clinical instability, reassess for continuing LOCD eligibility.
Door 4: Treatment and Conditions	
Daily oxygen therapy	**Documentation:** Physician orders and documentation of the beneficiary's limited ability to perform ADLs, including those ADLs not assessed for Door 1.
Door 6: Behavior	
Wandering	**Documentation:** The specific behaviors must be described in the assessment, nursing notes, case management notes and other documentation. If the beneficiary's safety is maintained by locked doors or other environmental features or by provider interventions, wandering must be scored based

	upon the historical behavior that necessitated the interventions or a medical professional's assessment of the risk associated with the absence of environmental or provider interventions.
Door 7: Service Dependency	
Criterion 1: Program participant for at least one year.	Includes continuous enrollment in a nursing facility (including therapeutic leave days), MI Choice, PACE, MI Health Link or any combination of these programs. Includes hospitalizations that do not result in disenrollment or discharge from a LTC program.
Criterion 2: Requires ongoing services to maintain current functional status.	Current services are necessary to prevent loss of function or worsening of medical conditions. "Current functional status" refers to the individual's ADLs and IADLs, cognitive performance, and behavioral issues. There is a basis for anticipating a significant decline in performance *if* services were removed. **Documentation:** The record must show a relationship between specific services presently received and the risk for functional decline with the removal of services. Documentation must support the need for ongoing services to maintain current functional status through (1) documentation of past problems that necessitated services, and (2) the clinical assessment identifying risk with the removal of services. An at-risk assessment is guided by the same clinical judgment used to develop service plans and discharge plans.
Criterion 3: No other community, residential or informal services are available to meet the applicant's needs.	"Other community services" would include those services for which the beneficiary is eligible, such as Home Help and other Medicaid services, Behavioral Health services, Medicare, private insurance, Veterans' benefits or Older American Act services. In addition to eligibility, the service must be available, i.e. no waiting lists, within a reasonable traveling distance. "Residential" refers to options that meet the beneficiary's service needs and are available to the beneficiary at the beneficiary's home or current living environment. "Informal services" refers to unpaid care provided by family members or friends who have the skills and capacity, choose to make the necessary commitment to the required schedule, live within a reasonable distance, and are acceptable to the beneficiary.

	Documentation: Providers are responsible for assessing community and residential service options and informal services when conducting an assessment and developing a plan of care or discharge plan. These determinations are based upon knowledge of local service options and interviews with family members and other options for informal services. Therefore, the provider must determine if this criterion is met and document that determination in the beneficiary record.

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