North Dakota Level of Care Form Instructions
To be used with LOC form ND 300-100, revised date 7-7-10

For this section, select which type of LOC screen is to be reviewed

Requested Screen Type

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

Select the most appropriate expected length of stay. Short-term is defined as stays no more than 120 days. Long-term is defined as stays greater than 120 days. Include the start date and indicate if this screen is a status change. A status change is defined as an improvement in a NF resident's medical status. Anytime the MDS is changed to indicate an improvement a new LOC screen should be submitted to Ascend.

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

Complete all information in the following section. A LOC screen cannot be processed without a social security number and date of birth.

Demographics

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

If the individual will be going to a NF or swing bed, complete the following section. Prior living situation is asking where the person was residing prior to their current location. Current location is asking where the individual currently is. List the Receiving Facility if known. Be sure to include all admission dates.

For NF/SB Screens Only:

Prior Living Situation: ☐ NF ☐ Basic Care ☐ Hospital ☐ Other (Specify): _____

Current Location: _____ Admission Date: _____
Contact Person: _____ Phone: _____ Fax: _____
Address: _____ City, State, Zip: _____

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

Complete the following section only if the screen is for the MFP program.

For MFP Screens Only:

Transition Coordinator Agency: _____

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

Detail the individual's medical diagnoses, both current and historical. These can often be found listed as Axis III diagnoses in medical records.

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

Section A

A.1 is for individuals who have Medicare Part A for the first 14 days and Medicaid and will be discharged no more than 30-days following screening. This criterion is for NF or Swing Bed only.

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

A.2 is for individuals in a comatose state. Our reviewers need to understand the diagnosis, cause, and date of onset of the condition. The approval could be long-term or short-term depending on the individual's prognosis.

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

For criterion A.3, it is important to note that the individual must rely on the use of the ventilator 6 hours per day, 7 days per week. Individuals who are weaning and do not need the ventilator 6 hours per day would not meet this criterion. It is important for our clinicians to know date of onset, diagnosis, cause, anticipated needs, and anticipated weaning schedule for the individual. This approval could be short-term or long-term depending on the needs of the individual.

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

Criterion A.4 is used for individuals who have respiratory problems. "Regular" means the services must occur daily or every other day. We need to understand the individual's treatment needs and the reason that she is unable to manage these services independently. It is important for our clinicians to understand the individual's diagnosis and nursing needs. The reason for assistance could be related to cognitive limitations or to physical limitations. The referral source should provide detailed information about those limitations and how they impact the individual's ability to self-manage respiratory treatment. Additional supporting documentation may include respiratory therapy notes, history and physical (H&P), home health notes, and nursing notes.

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

Criterion A.5 applies to individuals who need the physical presence of a caregiver for at least two of the following ADL's, toileting, eating, transferring, or locomotion. Verbal or physical assistance and cues are all considered physical presence. It is important for our clinicians to understand what type of assistance is needed, the frequency of assistance, the medical reason assistance is needed, and the anticipated duration of assistance needed.

5. ☐ The individual requires constant help at least 60% of the time with at least two (2) of the following Activities of Daily Living (ADLs). Constant help is required if the individual requires a caregiver's continual presence or help, without which the activity would not be completed. This criterion does not apply to individuals who need intermittent assistance.
   ☐ Toileting (e.g., use of toileting equipment, cleansing, adjustment of clothing)

☐ Eating (e.g., physical assistance with feeding or constant cues/prompting; does not include set-up or meal preparation such as cutting up food)
☐ Transferring (e.g., movement from surface to surface, such as bed to chair or chair to wheelchair)
☐ Locomotion (e.g., movement from place to place, such as room to room)

a. F or each ADL checked above, describe the assistance needed, including frequency of assistance: _____

b. E xplain why the individual is not able to self-manage these ADLs. Describe any cognitive and/or physical limitations. _____

For criterion A.6, our clinicians need to understand the diagnosis or reason for suctioning, the frequency of suctioning, the date suctioning began, and the length of time suctioning is expected to be required. Tracheostomy care does not qualify if the individual is able to self-manage.

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

Criterion A.7 applies to individuals who have a progressed dementia. Our clinicians need to understand what dementia-related deficits the individual is experiencing, how long those deficits have been an issue, and what impact those deficits have on the person's life. In order for the individual to meet this criterion, the dementia must cause significant impairment in the individual's life related to social functioning, occupational functioning, or safety. Give the month, day and year of the diagnosis. Note that a diagnosis alone for the period of 6 months is not sufficient without the supportive description.

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

If the individual does not meet any criteria in Section A, then the referral source should move on to Section B. Two items in Section B must be met in order for the individual to meet criteria.

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

For the review, it is important for our clinicians to understand what assistance the individual needs, such as set-up or physical assistance, and the frequency of that assistance. Set-up may include setting up syringes, med minders, or other medication administration devices. In order to meet this criterion, the medications must be prescribed as daily medications. It is also important for the referral source to communicate what physical or cognitive limitations prevent the individual from being able to self-administer medications. Psychiatric and medical medications are included under this criterion. List each medication, dosage, route, and date started.

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

Provide the following information for each medication prescribed:

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

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

_____

_____

_____

Criterion B.2 is for individuals with an unstable medical condition that requires care by or under the direction of a nurse. For individuals being served in the community, these services may be provided by a family member or other support person who has been trained by a nurse or higher-credentialed professional. "Regular" means the services must occur daily or every other day. Because instability is so individualized, it is important for our clinicians to understand the individual's entire clinical presentation when reviewing this criterion. There are many indicators of instability, such as fluctuations in lab values, vital signs, and levels; increase in frequency of doctor visits; and concurrent diagnoses, such as a recent upper respiratory infection, which can lead to instability in a chronic condition. It is important for the referral source to communicate the individual's experience with the medical condition and any other potentially related medical conditions in order to determine if the condition is unstable. Our clinicians also need to understand why the individual is unable to monitor the medical condition independently.

2. ☐ The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse, (or in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30 (b), a licensed practical nurse). For individuals being served in the community, these services may be provided by a family member or other support person who has been trained by a nurse or higher-credentialed professional.
   a. Identify the individual's unstable medical condition(s): _____

   _____
   b. Describe any recent fluctuations in the individual's medical presentation. This may include changes in lab values, vitals, or levels. It may also include increases in frequency of doctor visits. _____

   _____

   _____
   c. Describe the services needed related to unstable medical condition(s). Include frequency and who will be providing those services. _____

   _____

   _____
   d. Explain why the individual is not able to self-monitor the condition(s). Describe any cognitive and/or physical limitations: ____

   _____

   _____

Criterion B.3 applies to individuals who have restorative potential and require restorative nursing or therapy at least 5 days per week. Restorative nursing or therapy is focused on regaining lost skills and does not include maintenance services or prevention of deterioration. For the review, our clinicians need to understand what type of therapy or therapies the individual requires, the frequency of those therapies, who will be administering them, and the expected duration of the therapies. It is also important for us to understand what goals the individual has and what type of progress is being made toward those goals. An individual who receives a combination of different therapies that add up to 5 days per week may meet this criterion. This criterion cannot be met if family members are administering the therapies.

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

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

   _____
   c. Describe how long these services are expected to be needed (e.g., for the next month, indefinitely, etc): _____

   _____

For criterion B.4, our clinicians need to understand why the individual needs assistance with feedings by the specified methods. The referral source should detail any physical or cognitive limitations. It is also important for our clinicians to understand the diagnosis or reason for tube feedings, the frequency of feedings, and who will be administering feedings. Individuals can meet this criterion if feedings are administered by a family member or other caregiver. The emphasis of this criterion is on the individual's ability to self-administer.

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

Criterion B.5 is used for individuals who have a skin disorder that has a potential detrimental impact on the individual's overall physical health; therefore, our clinicians look not only at the current impact of the skin disorder but also at the potential impact if it is not treated properly. It is important for us to understand the type of skin disorder, the reason the individual needs assistance, the extent and type of treatment needed, and the location of the skin disorder. If there is a wound, it is important for us to understand the stage, size, treatment needed, and any other information that indicates the severity of the wound. An individual who has a yeast infection on his back and is unable to manage it himself due to obesity would meet this criterion.

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

This criterion applies to individuals who need the physical presence of a caregiver for toileting, eating, transferring, or mobility. Verbal or physical assistance and cues are all considered physical presence. It is important for our clinicians to understand what type of assistance is needed, the frequency of assistance, the medical reason assistance is needed, and the anticipated duration of assistance needed. The application of this criterion is exactly the same as A.5, except under this criterion the individual only requires assistance with one of the listed ADLs. This change is because under Section B, they must meet one other criterion in order to meet level of care.

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

If the individual does not meet level of care criteria under Sections A or B, the referral source may move on to Section C. Section C applies to individuals with brain or spinal cord injuries or individuals who have experienced some other traumatic injury and have restorative potential related to that injury. There is no age limit, so the individual does not necessarily have to meet the non-geriatric portion of this criterion. The focus of this criterion is on the individual's potential to regain lost skills. The individual must demonstrate gains and benefit over time. This criterion is used for individuals seeking services at Dakota Alpha only. Because this criterion focuses on the individual's restorative potential, is important for our clinicians to understand the individual's goals, progress toward goals, length of time progress is retained, types of rehab, and frequency of services in addition to the individual's diagnosis. It is also useful for the referral source to describe the length of time the individual has had the condition that needs rehab. If an individual's rehab has plateaued and he is no longer making gains, then he is no longer demonstrating restorative potential and is not appropriate under this criterion. For individuals with TBI, the definition of restorative care is broader than for other medical conditions and includes cognitive skill building, behavioral management, socialization skills, cooking skills, and other trainings aimed at fostering independence and remaining in the community.

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

☐ The individual is determined to have restorative potential. This criterion focuses on the individual's ability to regain lost skills. Maintenance and prevention of deterioration are not included in this criterion. Medical records are required for the review of this criterion in order to support the individual's needs.

a. Describe the diagnosis/condition which has led to the individual's need to regain lost skills: _____

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

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

Section D is for individuals who require nursing care for an acquired brain injury. Individuals with brain injuries may also meet under Sections A, B, or C. The brain injuries covered under this criterion are anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury. For the purposes of this criterion, "direct supervision" means the individual requires a caregiver to be present to provide oversight, prompts, and cueing. Physical assistance would also count as direct supervision. The caregiver can be a family member or a staff person at a rehabilitation program. The key consideration is that the supervision must add up to 8 hours per day, 7 days per week. For the review, it is important for our clinicians to understand the type of supervision required and the frequency of that supervision in order to demonstrate that the supervision is needed for 8 hours daily.

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

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

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

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

In the Additional Comments area, detail any information you feel was not addressed in a different part of the screen.

Additional Comments

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

_____
_____
_____
_____
_____
_____

Complete the following section completely. All information is required every time a screen is submitted.

Referral Source Information

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

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

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

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