

Required Documentation for Nursing Facility Level of Care Determination Submissions

This guidance lists the supporting documentation that must be included when submitting a Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) to MDHHS for review and approval. This applies to enrollees who are in a nursing facility, requesting approval for the MI Health Link HCBS Waiver, or maintaining enrollment in the MI Health Link HCBS Waiver. In addition to the completed and signed Freedom of Choice form, ICOs are required to submit only the information pertaining to the Door through which the enrollee appears to meet the LOCD.

If an enrollee is applying for the MI Health Link HCBS waiver in order to transition from a facility to the community, the ICO must complete a new LOCD and submit it to the state along with the appropriate documentation. ICOs do not need to submit any documentation to the State when adopting a pre-existing LOCD for an individual who was living in a nursing facility prior to enrolling in MI Health Link. For cases in which any piece(s) of the documentation are not available, care coordinators must provide an in-depth description of the observations they made during the in-person LOCD assessment, including their signature and the date.

LOCD documentation for HCBS waiver applications must be submitted through the Waiver Support Application (WSA) system. For LOCDs related to nursing facility stays, email the LOCD and its accompanying documentation in a secure manner to MSA-MHL-Enrollment@michigan.gov. If you have any questions, email INTEGRATEDCARE@michigan.gov with the subject line “NFLOCD Question.” Information on conducting the NFLOCD is available at: [http://www.michigan.gov/mdhhs/0,5885,7-339-71551\_2945\_42542\_42543\_42546\_42554-103102--,00.html](http://www.michigan.gov/mdhhs/0%2C5885%2C7-339-71551_2945_42542_42543_42546_42554-103102--%2C00.html).

**The ICO must submit the following based on the Door that the enrollee appears to meet:**

1. **Door 1 (ADLs):**
	1. Level 1 Assessment
		1. If the enrollee or representative declines the Level I assessment, other assessment data (such as the Minimum Data Set - MDS) and/or detailed observations of the enrollee by the Care Coordinator may be provided in lieu of the Level I assessment.
	2. Most recent care plan that supports entry through Door 1 or indicates in detail the amount and type of ADL assistance needed by the enrollee.
	3. Documentation by certified nursing assistants (CNAs) of the Activity of Daily Living (ADL) care that has been provided to the enrollee, and/or the care plan (Kardex) that identifies what ADL assistance is needed by the enrollee.
2. **Door 2 (Cognitive Performance):**
	1. Level 1 Assessment
	2. Mini Mental Status Exam (MMSE) or other cognitive tool (such as the BIMS)
	3. Most recent care plan that provides supporting evidence of enrollee’s cognitive deficits and safety concerns
3. **Door 3 (Physician Involvement):**
	1. Level 1 Assessment
	2. Copies of appointment records for the physicians, nurse practitioners, and physician’s assistants that the enrollee has visited in the past 14 days
	3. Copies of new orders and order changes that were made by the enrollee’s providers in the past 14 days
	4. Most recent care plan containing restorative nursing interventions and specific discharge plan as appropriate
4. **Door 4 (Treatments and Conditions):**
	1. Stage 3-4 pressure sores:
		1. Level 1 assessment
		2. Copy of wound care orders
		3. Copy of wound care progress notes
		4. Most recent care plan containing restorative nursing interventions and specific discharge plan
	2. IV or parenteral feedings:
		1. Level 1 assessment
		2. Copy of physician order for feedings
		3. Most recent care plan containing restorative nursing interventions and specific discharge plan
	3. Intravenous medications:
		1. Level 1 assessment
		2. Copy of physician orders for current intravenous medications
		3. Most recent care plan containing restorative nursing interventions and specific discharge plan
	4. End-Stage care:
		1. Level 1 assessment
		2. Copy of physician orders regarding end-stage care
		3. Most recent care plan
	5. Daily tracheostomy care, daily respiratory care, daily suctioning:
		1. Level 1 assessment
		2. Copy of physician orders regarding trach care, respiratory care, or suctioning
		3. Most recent care plan containing restorative nursing interventions and specific discharge plan
	6. Pneumonia within the last 14 days:
		1. Level 1 assessment
		2. Copy of pneumonia diagnosis
		3. Most recent care plan containing restorative nursing interventions and specific discharge plan
	7. Daily oxygen therapy:
		1. Level 1 assessment
		2. Copy of current physician order for oxygen
		3. Enrollee’s most recent care plan containing restorative nursing interventions and specific discharge plan
	8. Daily insulin with two order changes in the last 14 days:
		1. Level 1 Assessment
		2. Copies of the new order changes
		3. Most recent care plan containing restorative nursing interventions and specific discharge plan
	9. Peritoneal or hemodialysis:
		1. Level 1 Assessment
		2. Copy of physician order for dialysis
		3. Most recent care plan containing restorative nursing interventions and specific discharge plan
5. **Door 5 (Skilled Rehabilitation Therapies):**
	1. Level 1 Assessment
	2. Copy of PT/OT/ST assessment(s) including scope and duration of sessions
	3. Copies of physician orders for PT/OT/ST
	4. Copies of therapy session notes
	5. Most recent care plan containing restorative nursing interventions and specific discharge plan
6. **Door 6 (Behaviors):**
	1. Level 1 Assessment
	2. PASARR Level 2 Assessment if available
	3. Copy of psychiatric consult notes
	4. Behavior log if available
	5. Most recent care plan
7. **Door 7 (Service Dependency):**
	1. Documentation showing that beneficiary was served in MI Choice, MI Health Link, PACE, or a Medicaid reimbursed nursing facility for the past 12 consecutive months, **AND**
	2. Detailed documentation showing that the beneficiary requires ongoing services to maintain current functional status, **AND**
	3. Additional detailed documentation that specifically addresses how the beneficiary’s needs cannot be met by any other community, residential, or informal services.
8. **Door 8 (Exception Criteria):**
	1. Frailty:
		1. Documentation of the unreasonable amount of time which enrollee needs to perform bed mobility, toileting, transferring, or eating activities independently.
			* Things to consider and possibly send to MDHHS for review as applicable: Amount of *time* to perform any of the ADLs listed, not the ability level to perform it.  Look for something in the record that documented the amount of time it took the beneficiary to perform the ADL (even if they were independent in that ADL) and if it was an unreasonable amount of time (five real minutes or longer).
		2. Documentation showing that the enrollee’s performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity.
			* Things to consider and possibly send to MDHHS for review as applicable: check the record to see if ADL performance, although independent and/or not a time constraint, impacted the individual’s breathing which lead to consistent shortness of breath, pain and debilitating weakness.  They have to be impacted by shortness of breath, pain, debilitating weakness for at least 15 real minutes.
		3. Documentation showing that the enrollee has fallen two or more times in their home in the past month.
			* Things to consider and possibly send to MDHHS for review as applicable: the fall must be associated with dizziness, lightheadedness, gate problems or symptoms that are routinely experienced.
		4. Documentation showing that the enrollee is unable to manage his/her own medication administration despite receiving medication set-up services.
			* Things to consider and possibly send to MDHHS for review as applicable: medication management typically wouldn’t apply because NFs administer medications. Residents are asked upon admit if they’d like to self-medicate but most choose not to do so. This is more for persons in the community; the individual would have to have medication management for at least one month, but still experienced health issues related to managing those medications (like mismanaging despite have medication set-up).
		5. Documentation showing that the enrollee has inadequate nutritional intake, such as continued weight loss, despite receiving meal preparation services.
			* Things to consider and possibly send to MDHHS for review as applicable: check to see if there’s a significant weight loss (10 pounds or more) or signs of poor nutrition despite the fact that the beneficiary was receiving meal preparation for at least one month.
		6. Documentation showing that the enrollee meets the criteria for Door 3 when emergency room visits for clearly unstable conditions are considered.
			* Things to consider and possibly send to MDHHS for review as applicable: use the same criteria for Door 3 on the LOCD except that MDHHS permits emergency room visits to be counted for Door 8 (we don’t include this on Door 3).
	2. Behaviors:
		1. Documentation showing that the enrollee has at least a one month history of any of the following behaviors, and has exhibited two or more of any these behaviors in the last seven days, either one at a time or in combination:
			* Wandering
			* Verbal or physical abuse
			* Socially inappropriate behavior
			* Resists care

Behaviors Documentation (cont.): Things to consider and possibly send to MDHHS for review as applicable: Behaviors should be noted in the record by the Social Worker or Nurse.  When it comes to Resisting care, you have to be careful to account for the fact that residents have the right to refuse a treatment plan; that’s not really resisting care. Resisting care is defined in the LOCD (pushing, shoving, scratching, etc).

* 1. Treatments:
		1. Documentation demonstrating that the enrollee has a need for complex treatments or nursing care.