Nursing Facility Level of Care Determination Tool (LOCD) Supporting Documentation Examples for Verification Review and Secondary Review

This guidance document lists examples of supporting documentation that may be used when uploading documentation in CHAMPS for LOCD Verification Reviews or LOCD Secondary Reviews. The documentation will be reviewed by Michigan Peer Review Organization (MPRO).

Documentation Examples by LOCD Door

**MPRO can only provide a review if the LOCD has been conducted and entered in CHAMPS. Supporting documentation must be uploaded in CHAMPS within required timeframes.*

All supporting documentation should cover the timeframe of the LOCD look-back period (either 7 or 14 days depending on the qualifying Door, unless it is Door 8 which has varying look-back periods of 30 and 60 days). If a piece of documentation cannot be submitted, the provider should include a separate signed document with explanation.

Door 1 (Activities of Daily Living)

- Documentation showing the Activity of Daily Living (ADLs) care that was provided to the individual each day during the look-back period.
- Current Minimum Data Set (MDS)assessment
- InterRAI-HC (Level II) assessment
- Personal Care assessment

Door 2 (Cognitive Performance)

- Completed cognitive tool, such as the Mini Mental Status Exam (MMSE), Brief Interview for Mental Status (BIMS) or St. Louis University Mental Status Examination (SLUMS).
- Nursing home staff notes and/or care coordinator notes detailing specific examples of individual's impaired decision-making abilities. Notes or narratives must be signed and dated by the health professional creating them.
- InterRAI-HC (Level II) assessment
- Completed cognitive tool, such as the Mini Mental Status Exam (MMSE), Brief Interview for Mental Status (BIMS), or St. Louis University Mental Status Examination (SLUMS).
- Care coordinator notes detailing specific examples of individual's impaired decision-making abilities. Notes or narratives must be signed and dated by the health professional creating them.

Door 3 (Physician Involvement)

- Copies of appointment records for the physicians, nurse practitioners, and physician's assistants that the individual has visited in the past 14 days. Do not count emergency room examinations or hospitalizations.
  - Copies of new orders and order changes that were made by the individual 's providers in the past 14 days. Order changes must take place on more than one day. **If the individual has multiple physician visits and multiple order changes on the same day, this counts as one physician visit and one order**

change per day. Do not include drug or treatment order renewals that did not change. Do not count physician orders in the emergency room.

Door 4 (Treatments and Conditions)

NOTE: For all treatments and conditions listed below, the following must also be true – the treatment or condition must affect the individual's functioning or need for care and has not yet resolved. A continuing need must exist.

- **Stage 3-4 pressure sores:**
  - Current wound care orders
  - Current wound care progress notes
  - Physician documented diagnosis of Stage 3 or 4 pressure ulcer.
- **IV or parenteral feedings:**
  - Current physician order for feedings
  - Physician documented diagnosis of health condition causing need for feedings.
- **Intravenous medications:**
  - Current physician orders for intravenous medications
  - Physician documented diagnosis of health condition causing need for IV medications.
- **End-Stage care:**
  - Documentation **signed by the hospice enrollment physician** certifying that the individual has a terminal illness with a prognosis of six months or less.
- **Daily tracheostomy care, daily respiratory care, daily suctioning:**
  - Current physician orders regarding daily trach care, respiratory care, and suctioning.
  - Physician documented diagnosis of health condition causing need for daily trach care, daily respiratory care, or daily suctioning.
- **Pneumonia within the last 14 days:**
  - Physician-documented pneumonia diagnosis **within last 14 days.**
  - Documentation showing a need for assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), or restorative nursing care **related to the pneumonia**.
- **Daily oxygen therapy:**
  - Current physician order for oxygen.
  - Physician-documented diagnosis of health condition causing need for oxygen.
  - Documentation showing a need for assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), or restorative nursing care **related to need for oxygen**.
- **Daily insulin with two order changes in the last 14 days:**
  - Order changes for daily insulin **within last 14 days**.
  - Physician-documented diagnosis of health condition causing need for insulin.

- **<u>Peritoneal or hemodialysis</u>:**
    - Current physician order for dialysis.
    - Physician-documented diagnosis of health condition causing need for dialysis.
    - Documentation showing a need for assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), or restorative nursing care **related to need for dialysis**.

Door 5 (Skilled Rehabilitation Therapies)

- Physical, Occupational, and/or Speech Therapy assessment(s) including amount of therapy administered and amount scheduled.
- Physician orders for Physical, Occupational, and/or Speech Therapy
- **One of these items must cover the 7-day look-back period and a continuing need must exist.**

Door 6 (Behaviors)

- Current psychiatric Level II assessment such as the Biopsychosocial, Supports Intensity Scale (SIS), Level of Care Utilization System (LOCUS), or American Society of Addiction Medicine (ASAM) tool.
- Nursing notes showing history of wandering, verbal abuse, physical abuse, socially inappropriate/disruptive behaviors, resisting care, delusions, or hallucinations during the 7-day look-back period.
- Psychiatric consult notes or other physician notes (if available)
- PASRR Level 2 Assessment (if available)
- InterRAI-HC (Level II) assessment
- Care coordinator notes showing history of wandering, verbal abuse, physical abuse, socially inappropriate/disruptive behaviors, resisting care, delusions, or hallucinations during the 7-day look-back period. Notes or narratives must be signed and dated by the health professional creating them.
- Psychiatric consult notes or other physician notes (if available).

Door 7 (Service Dependency)

- Detailed documentation showing that the beneficiary has been in any long-term care program requiring LOCD eligibility for more than one year (*provide timeframe*), requires ongoing services to maintain current functional status (*what services are currently being provided?),* and no other community, residential or informal services are available to meet the beneficiary's needs (*what other settings were considered?*). Notes or narratives must be signed and dated by the health professional creating them.

Door 8 (Exception/Frailty Criteria)

MPRO may go back up to two months (see timeframe for each criteria).

<u>Frailty</u>:

- Documentation of the unreasonable amount of time which individual needs to perform bed mobility, toileting, transferring, or eating activities independently.
    - Things to consider and possibly send to MPRO 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 documents the amount of time it took the individual to perform the ADL (even if they were independent in that ADL) and if it was an unreasonable amount of time. Notes or narratives must be signed and dated by the health professional creating them.

- Documentation showing that the individual's performance is impacted by consistent shortness of breath, pain, or debilitating weakness during any activity.
    - Things to consider and possibly send to MPRO 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. The individual must be impacted by shortness of breath, pain, debilitating weakness for at least 15 real minutes. Notes or narratives must be signed and dated by the health professional creating them.
- Documentation showing that the individual has fallen two or more times in their home in the past month.
    - Things to consider and possibly send to MPRO for review as applicable: the falls must be associated with dizziness, lightheadedness, gait problems or symptoms that are routinely experienced. Notes or narratives must be signed and dated by the health professional creating them.
- Documentation showing that the individual is unable to manage his/her own medication administration despite receiving medication set-up services.
    - Things to consider and possibly send to MPRO for review as applicable: medication management typically does not apply because nursing facilities administer medications. Residents are asked upon admission if they would like to self-medicate but most choose not to do so. 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). Notes or narratives must be signed and dated by the health professional creating them.
- Documentation showing that the individual has inadequate nutritional intake, such as continued weight loss, despite receiving meal preparation services.
    - Things to consider and possibly send to MPRO for review as applicable: check to see if there was a significant weight loss or signs of poor nutrition even though the beneficiary was receiving meal preparation for at least one month. Notes or narratives must be signed and dated by the health professional creating them.
- Documentation showing that the individual meets the criteria for Door 3 when emergency room visits for clearly unstable conditions are considered.
    - Things to consider and possibly send to MPRO for review as applicable: use the same criteria for Door 3 on the LOCD except that MPRO permits emergency room visits to be counted for Door 8. Notes or narratives must be signed and dated by the health professional creating them.

Behaviors:

- Documentation showing that the individual 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
    - Things to consider and possibly send to MPRO for review as applicable: Behaviors should be noted in the record by the Social Worker or Nurse. **When it comes to Resisting Care, be careful to account for the fact that individuals have the right to refuse a treatment plan.** Resisting care is defined in the LOCD (pushing, shoving, scratching, etc.). Notes or narratives must be signed and dated by the health professional creating them.

Treatments:

- Documentation demonstrating that the individual has a need for complex treatments or nursing care. Notes or narratives must be signed and dated by the health professional creating them.