Nursing Facility Level of Care Eligibility Manual
## Revision History Log

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<td>Author</td>
<td>Office of Aging and Adult Services (OAAS)</td>
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### Revision History

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<tr>
<td>9/23/11</td>
<td>Section 5.3 (1)</td>
<td>Behavior Pathway</td>
<td>15-16</td>
<td>Removed item <em>v. Resisted Care</em> from list. This item was inadvertently included previously, but is not part of the NFLOC algorithm for triggering the Behavior Pathway.</td>
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<td>9/23/11</td>
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<tr>
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<tr>
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<td>Section 5.3</td>
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<td>Reworked last sentence of first paragraph as follows: ...during the look back period as specified in the applicable screening/assessment tool.</td>
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<td>Use of the LOCET to Determine NFLOC Eligibility</td>
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<td>Review of Physician Involvement, Treatments &amp; Conditions &amp; Skilled Rehab Therapies Pathways</td>
<td>27</td>
<td>Corrected wording on item #9 to read “...in the event that an individual does not meet...”</td>
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<td>Section</td>
<td>Revised Paragraph</td>
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<td>Section 7.7.2</td>
<td>PACE Deeming Procedure</td>
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<td>Permanent Waiver of Annual Recertification for PACE Participants</td>
<td>33-36 Added this Section to reflect this new PACE process.</td>
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<td>Degree of Difficulty Questions (DDQ) Overview</td>
<td>37 Revised paragraph wording under Section 8.0 for clarity.</td>
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<td>Included Important Note regarding application of DDQs to nursing facility residents.</td>
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<td>Added P.2.h. IV infusion – Central to Table 1</td>
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<td>Included Important Note regarding DDQs not applied to nursing facility residents, or individuals in a hospital (e.g., rehabilitation facility, long term acute care facility, psychiatric hospital, etc.).</td>
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<tr>
<td>5/07/18</td>
<td>All Sections</td>
<td>Changed and renumbered all sections, changed working of LOC to NFLOC, added table to include links to program requirements and manuals, updated links in document, deleted pathway and appendix charts, deleted PACE procedures to reflect only those relative to NFLOC and eligibility, added information regarding LT-PCS &amp; ITC, and revised language and formatting throughout the document to clarify information and for easier readability.</td>
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1.0 OVERVIEW

The Level of Care (LOC) determination assures a consistent and reliable process for determining that individuals meet the functional/medical eligibility requirements for admission to and continued stay in a nursing facility or certain Home and Community-Based Service (HCBS) funded through the Medicaid Program. The LOC determination for these services/programs is referred to as the “Nursing Facility Level of Care (NFLOC) determination.”

The NFLOC determination process assists individuals with long-term or chronic health care needs in making informed decisions and in choosing options that reflect their preferences and meet their needs in the least restrictive way possible.

The Louisiana Department of Health (LDH), Office of Aging and Adult Services (OAAS), is the State agency responsible for oversight and determination of functional/medical eligibility for individuals applying for or who are receiving Medicaid-funded nursing facility care or certain HCBS administered by OAAS, including the Community Choice Waiver (CCW), Adult Day Health Care (ADHC) Waiver, Long Term-Personal Care Services (LT-PCS) and Program of All-Inclusive Care for the Elderly (PACE).

The program services administered by OAAS are provided to eligible individuals with a range of functional and cognitive abilities. Improving the ability of the health care delivery system to respond to the needs of all of these individuals in an equitable, streamlined, and fiscally responsible manner, is a primary and ongoing goal and responsibility of OAAS.

2.0 PURPOSE and SCOPE

The purpose of this manual is to provide instructions and guidance regarding the uniform NFLOC eligibility criteria and NFLOC review processes that must be followed by OAAS and/or its designees.

This manual shall be used in conjunction with the Louisiana Department of Health (LDH) Medicaid manuals and other OAAS program manuals that provide more detail about policies and procedures regarding Long-Term Care HCBS programs and services. References are made throughout this manual, as applicable, to guide the reader when specific program and other requirements are beyond the scope of this manual.

3.0 Authority

This document draws from a combination of federal and state laws, as well as Louisiana Department of Health (LDH) policy which specify the standards and procedures that must be followed in determining medical/functional eligibility for nursing facility services and HCBS.
programs. Should a conflict exist between this manual’s content and pertinent federal and state laws or regulations, the latter will take precedence.

The primary authority and basis for the protocols and directives outlined in this NFLOC Eligibility policy manual come from The Nursing Facilities—Standards for Payment, Level of Care Determination (LAC 50:II. §10154 and§10156). See Appendix A.

(a) Applicability. The rules and policies referenced in this manual apply to nursing facility services and Home and Community-Based Services funded through Medicaid HCBS Waivers, Long Term Personal Care Services (LT-PCS) (Medicaid State Plan Services), and the Program of all Inclusive Care for the Elderly (PACE).

(b) Program Administration and Operation. The Louisiana Department of Health (LDH), in partnership with the Centers for Medicare and Medicaid (CMS), federal agency, and the Bureau of Health Services Financing (BHSF)/Louisiana Medicaid, administers the Medicaid-reimbursed programs and services operated by the OAAS.

BHSF, in partnership with OAAS, develops program rules, regulations, manuals, policies, and procedures for the operation and oversight of these programs.

4.0 Participant Eligibility Requirements

Each long-term care program administered by OAAS has specific eligibility requirements for participants that must be met in order for an individual to be determined eligible. These eligibility requirements can be grouped into three (3) major categories:

- Medicaid financial eligibility;
- Medical/functional eligibility/Nursing Facility Level of Care (NFLOC); and
- Program requirements.

4.1 Medicaid Financial Eligibility

Financial eligibility for Medicaid-funded programs is determined by local Medicaid Eligibility staff. Maximum income and resource limits are announced each year by the LDH Medicaid division. Fact sheets for OAAS programs/services include a summary of current income and resource limits, and are posted on OAAS website at: http://www.dhh.louisiana.gov/index.cfm/newsroom/detail/1433
Medicaid financial eligibility rules are complex. Certain income and resources may be excluded from these limits. Due to this complexity, OAAS employees and/or designees are instructed to refer individuals who are not yet Medicaid eligible to the Medicaid Eligibility office. Information regarding the Medicaid application and eligibility process can be found on the Healthy Louisiana website: http://ldh.louisiana.gov/index.cfm/subhome/48.

4.2 Functional/Medical Eligibility

OAAS utilizes prescribed, uniform screening and assessment tools to gather critical data for the purpose of determining whether an individual meets the Nursing Facility Levels of Care (NFLOC) criteria.

Individuals who are approved by OAAS, or its designee, as having met NFLOC, must continue to meet medical/functional eligibility criteria on an ongoing basis.

Louisiana establishes NFLOC via the use of scientifically-validated and reliability-tested screening and assessment tools which are utilized upon initial application and program eligibility redetermination periods.

There are several, distinct pathways by which an individual can be determined to meet NFLOC eligibility criteria. These pathways are described in detail in section 5.0 of this manual.

4.3 Program Requirements

In addition to meeting Medicaid financial and functional/medical eligibility requirements/NFLOC, individuals must also meet all program specific requirements before they can be determined eligible for a particular program. Specific program requirements are defined in program rules, policies, and program manuals.

Louisiana State Regulations for each program can be found in the Louisiana Register under the Louisiana Administrative Code (LAC) at the following website http://www.doa.la.gov/Pages/osr/lac/books.aspx. Please see the LAC Rule associated with each program in the table below.
| Program | Program Requirements Eligibility | Fact Sheets | LAC Rule & Medical Provider Manual/
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<tr>
<td><strong>Adult Day Health Care (ADHC) Waiver</strong></td>
<td>• Name on the Request for Services Registry for the ADHC Waiver; • Health and safety requirements; and • Appropriateness, cost-effectiveness, and least restrictive environment guidelines. <strong>FOR ADHC WAIVER &amp; LT-PCS TOGETHER:</strong> Not only must meet NFLOC but also must require at least limited assistance with any one (1) Activity of Daily Living</td>
<td><a href="http://ldh.la.gov/assets/docs/OAAS/publications/FactSheets/ADHC-Fact-Sheet.pdf">http://ldh.la.gov/assets/docs/OAAS/publications/FactSheets/ADHC-Fact-Sheet.pdf</a></td>
<td>LAC Rule: 50:XXI.2101-2915 Medicaid Provider Manual: <a href="http://www.lamedicaid.com/provweb1/Providermanuals/manuals/ADHC/ADHC.pdf">http://www.lamedicaid.com/provweb1/Providermanuals/manuals/ADHC/ADHC.pdf</a></td>
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<tr>
<td><strong>Long-Term Personal Care Services (LT-PCS) ONLY</strong></td>
<td>• Must meet NFLOC AND must require at least limited assistance with any one (1) Activity of Daily Living; • Direct care independently or through a responsible representative; and • Faces a substantial possibility of deterioration</td>
<td><a href="http://ldh.la.gov/assets/docs/OAAS/publications/FactSheets/LT-PCS_Fact_Sheet.pdf">http://ldh.la.gov/assets/docs/OAAS/publications/FactSheets/LT-PCS_Fact_Sheet.pdf</a></td>
<td>LAC Rule: 50:XV.12901-12919 Medicaid Provider Manual: <a href="http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PCS/pcs.pdf">http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PCS/pcs.pdf</a></td>
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| ADHC Waiver & LT-PCS together then refer to ADHC Waiver requirements | if either HCBS or nursing facility services is not provided in less than 120 days. (This is called Initial Targeting Criteria)  
  o Individual is in a nursing facility and could be discharged if community-based services were available;  
  o Is likely to require nursing facility admission within the next 120 days; or  
  o Has a primary care giver who has a disability or is over the age of 70. |  

| Nursing Facility Services: | • Any individual seeking NF Services to a Medicaid certified NF must be assessed for NF services regardless of the individual’s payer source; and  
  • Screening prior to admission for a suspicion of mental illness and/or developmental disabilities according to federal regulations. | http://ldh.la.gov/assets/docs/OAAS/publications/FactSheets/Nursing-Facilities-Fact-Sheet.pdf  
LAC Rule: 50:II.501-511 |
|---|---|---|
| Program for All-Inclusive Care for the Elderly (PACE) | • Health and safety requirements | http://ldh.la.gov/assets/docs/OAAS/publications/FactSheets/PACE_Fact-Sheet.pdf  
LAC Rule: 50:XXIII.101-1301  
5.0 Nursing Facility Level of Care Pathways

Several potential avenues of functional and medical eligibility are investigated by OAAS or its designees during the NFLOC eligibility determination process. These avenues are called **pathways**. These pathways are utilized to ensure consistency, uniformity, and reliability in making NFLOC determinations and are as follows. The distinct NFLOC pathways are:

- Activities of Daily Living
- Cognitive Performance
- Physician Involvement
- Treatments and Conditions
- Skilled Rehabilitation Therapies
- Behavior
- Service Dependency

When specific eligibility criteria are met within a pathway, that pathway is said to have "triggered".

In order to meet the NFLOC criteria, an individual must meet eligibility requirements in **ONLY ONE (1)** of the pathways described in this section.

The Level of Care pathways elicit specific information within a specified evaluation period, regarding the individual's

- Functional capabilities;
- Receipt of [human] assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs);
- Current medical treatments and conditions; and
- Other aspects of the individual's life.

Almost all NFLOC assessment items refer to the individual's status over a designated time period (look-back/look-forward periods). Look-back/look-forward time periods are looking back/forward from a specified date that are commonly referred as the Assessment Reference Date (ARD), observation period or assessment period. Time periods vary based on the assessments and can range from 3-day, 7-day, 14-day, or longer. In other words, the certified assessor is “looking back” or “looking forward” from the specified date in order to capture the data requested.

**NOTE:** In determining NFLOC, staff should utilize the time periods established in this manual. These timeframes take into consideration various factors based on the assessment tool and community and nursing facility resident involvement.

5.1 Activities of Daily Living (ADL) Pathway

The intent of the ADL pathway is to determine the individual's self-care performance in Activities of Daily Living (ADLs) during a specified look-
back period utilizing the prescribed screening and assessment tools. The ADL pathway identifies those individuals with a significant loss of independent function as measured by the amount of assistance received from another person during the specified look-back period. The ADLs for which the NFLOC screening and assessment tools elicit information are:

- Locomotion—moving around in the individual's home;
- Dressing—how the individual dresses/undresses;
- Eating—how food is consumed (does not include meal preparation);
- Bed mobility—moving around while in bed (includes sitting up and lying down once in the bed);
- Transferring—how the individual moves from one surface to another (excludes getting on and off the toilet and getting in and out of the tub/shower);
- Toileting—includes getting on and off the toilet, wiping, arranging clothing, etc.;
- Personal hygiene (excludes baths/showers); and
- Bathing (excludes washing of hair and back).

In order for an individual to meet the NFLOC eligibility criteria in the ADL pathway, the individual must score at the:

- **Limited assistance** level or greater (as defined by the NFLOC screening/assessment instrument) on toilet use, or transferring, or bed mobility; or
- **Extensive assistance** level or greater (as defined by the NFLOC screening/assessment instrument) on eating.

### 5.2 Cognitive Performance Pathway

The Cognitive Performance pathway identifies individuals who experienced difficulty during the specified look-back period in the areas listed below:

- Short term memory which determines the individual's functional capacity to remember recent events;
- Cognitive skills for daily decision making which determines the individual's actual performance in making everyday decisions about tasks or activities of daily living such as:
  - Planning how to spend his/her day;
  - Choosing what to wear; or
  - Reliably using canes, walkers or other assistive devices/equipment, if needed;
• Making self understood which determines the individual’s ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

In order for an individual to meet the NFLOC eligibility criteria in the Cognitive Performance pathway, the individual must have the type and level of impairment (during the specified NFLOC look-back period) in any one (1) of the conditions noted below:

• Individual is severely impaired in daily decision making (i.e., never or rarely made decisions); or
• Individual has a short term memory problem and daily decision making is moderately impaired (i.e., decisions are consistently poor or unsafe; cues or supervision is required at all times); or
• Individual has a memory problem and is sometimes understood (i.e., ability is limited to making concrete requests); or
• Individual has a short term memory problem and is rarely or never understood; or
• Individual is moderately impaired in daily decision making (i.e., decisions are consistently poor or unsafe; cues or supervision is required at all times), and the individual is usually understood (i.e., difficulty finding words or finishing thoughts; prompting may be required); or
• Individual is moderately impaired in daily decision making (i.e., decisions are consistently poor or unsafe; cues or supervision is required at all times), and the individual is sometimes understood (i.e., ability is limited to making concrete requests); or
• Individual is moderately impaired in daily decision making (i.e., decisions are consistently poor or unsafe; cues or supervision is required at all times), and the individual is rarely or never understood; or
• Individual is minimally impaired in daily decision making (i.e., has some difficulty in new situations or decisions are poor and requires cueing/supervision in specific situations only), and the individual is sometimes understood (i.e., ability is limited to making concrete requests); or
• Individual is minimally impaired in daily decision making (i.e., some difficulty in new situations or decisions are poor and requires cueing/supervision in specific situations only), and the individual is rarely or never understood.
5.3 Physician Involvement Pathway

The intent of the Physician Involvement pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for him/herself.

Physician visits and physician orders are investigated, with consideration given to physician visits (excluding emergency room exams) and physician orders (excluding order renewals without change and hospital inpatient visits). Physician visits and orders in a nursing facility may be counted.

In order for an individual to be APPROVED in the Physician Involvement pathway, the individual must have:

- One day of doctor visits and at least four (4) new order changes all occurring during the 14-day look back period; or
- At least 2 days of doctor visits and at least 2 new order changes all occurring during the 14-day look-back period; and
- Supporting documentation must be provided for the specific qualifying criteria above.

Acceptable supporting documentation includes, but is not limited to:

- A copy of the physician’s orders; or
- Home health care plans documenting the diagnosis, treatments and conditions within the designated timeframes; or
- The appropriate form designated by OAAS to document the individual’s medical status and condition. This may include the Statement of Medical Status Form; or
- Other supporting documentation may also include:
  - Hospital/nursing facility discharge plan, or physician’s notes which document the diagnosis, treatments and conditions occurring during the designated time frame; or
  - Provider/support coordinator service logs documenting conversations with medical professionals to verify visits and/or orders; or
  - The assessor’s direct observation of items required for this pathway (medication bottles for new medications ordered, etc.).

This pathway is approved for time limited services/length of stay, as deemed applicable by OAAS or its designees.

5.4 Treatments and Conditions Pathway

The intent of the Treatments and Conditions pathway in the NFLOC process is to identify individuals with unstable medical conditions that may be affecting a person’s ability to care for him/herself. For a person to meet this pathway, the person must have:
• In the 7 days before the assessment: Intravenous (IV) feedings; or

• In the 14 days before the assessment any of the below:
  o Stage 3-4 pressure sores; or
  o Intravenous (IV) medications to treat a condition; or
  o Daily tracheostomy care and ventilator/respiratory suctioning (This refers to any one of these task); or
  o Pneumonia and the individual needed help with IADLs, ADLs, or restorative nursing care during this time; or
  o Daily respiratory therapy provided by a qualified professional; or
  o Daily insulin injections with two or more order changes; or
  o Peritoneal or hemodialysis.

Acceptable supporting documentation includes, but is not limited to:
• A copy of the physician’s orders; or
• Home healthcare plans documenting the diagnosis, treatment and conditions within the designated timeframes; or
• The appropriate form designated by OAAS to document the individual’s medical status and condition. This may include the Statement of Medical Status Form; or
• Other supporting documentation may also include:
  o Hospital/nursing facility discharge plan, or physician’s notes which document the diagnosis, treatments and conditions occurring during the designated time frame; or
  o provider/support coordinator service logs documenting conversations with medical professionals to verify the receipt of treatments or conditions; or
  o the assessor’s direct observation of the treatment or condition.

This pathway is approved for time limited services/length of stay, as deemed applicable by OAAS or its designees.

5.5 Skilled Rehabilitation Therapies Pathway

The intent of this pathway is to identify individuals who have received, or are scheduled to receive, at least 45 minutes of physical therapy, occupational therapy, or speech therapy within the specified 7-day look-back period, or within the specified 7-day look-forward period.

In order for an individual to be APPROVED in the Skilled Rehabilitation Therapies pathway, the individual must:

• Have received at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy during the, 7-day look-back period; or
• Be scheduled to receive at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy within the 7-day look-forward period.

NOTE: The above does not include assessments or evaluations.

This pathway is approved for time limited services/length of stay, as deemed applicable by OAAS or its designees.

Supporting documentation must also be provided for the specific qualifying criteria listed above. Acceptable supporting documentation includes, but is not limited to:

• A copy of the physician’s orders for the received/scheduled therapy; or
• Home health care plan notes indicating the received/scheduled therapy; or
• Progress notes indicating the physical, occupational, and/or speech therapy received or scheduled; or
• Nursing facility or hospital discharge plans indicating the therapy received/scheduled; or
• The appropriate form designated by OAAS to document the individual’s medical status and condition. This may include the Statement of Medical Status Form; or
• Other supporting documentation may also include:
  o Hospital/nursing facility discharge plan, or physician’s notes which document the diagnosis, treatments and conditions occurring during the designated time frame; or
  o Provider/support coordinator service logs documenting conversations with medical professionals to verify therapy received or scheduled, or
  o The assessor’s direct observation of the skilled rehabilitation/therapy.

5.6 Behavior Pathway

The intent of this pathway is to identify individuals who have experienced repetitive behavioral challenges which have impacted his/her ability to function in the community during the specified screening/assessment look-back period.

The following are investigated for this pathway:

• Wandering;
• Verbally or physically abusive behavior;
• Socially inappropriate behavior; and
• Delusions or hallucinations.
In order for an individual to meet the NFLOC eligibility criteria in the Behavior pathway, the individual must have either:

- Exhibited any one of the following behaviors four (4) or more days of the screening tool’s seven (7)-day look-back period when utilizing the LOCET (OR) exhibited any of the following behaviors during the three (3) day look-back period when utilizing the MDS-HC:
  - Wandering;
  - Verbally abusive;
  - Physically abusive; or
  - Socially inappropriate or disruptive; or
  - Experienced delusions or hallucinations that impacted his/her ability to live independently in the community within the specific screening/assessment tool’s look-back period.

5.7 Service Dependency Pathway

The intent of this pathway is to identify individuals who are currently in a nursing facility or receiving services through the Adult Day Health Care (ADHC) Waiver, the Community Choices Waiver, Program of All Inclusive Care for the Elderly (PACE) or receiving Long Term Personal Care (LT-PCS).

In order for individuals to be approved under this pathway, the aforementioned services must have been approved prior to December 1, 2006 and ongoing services are required in order for the individual to maintain current functional status. There must have been no break in services during this time period.

6.0 Uniform NFLOC Screening and Assessment Tools

This section provides a description of the prescribed uniform NFLOC screening and assessment tools and related processes utilized by OAAS and/or its designees to assess and determine an individual’s initial and ongoing NFLOC eligibility status.

6.1 Level of Care Eligibility Tool (LOCET)

The Level of Care Eligibility Tool (LOCET) is an algorithm-based screening tool used by OAAS and/or its designated entities during the initial intake screening process to ascertain whether an individual “presumptively” meets the Nursing Facility NFLOC eligibility criteria, as described in Section 5.0, or via application of Degree of Difficulty Questions (DDQs) described in Section 8.0 of this manual, for the identified OAAS programs.

The LOCET is designed to be an automated, easily administered, person-centered screening tool. The LOCET is compatible with the
congressionally mandated Resident Assessment Instrument (RAI) used in nursing facilities in the United States and several countries abroad (the RAI is also referred to as the *Minimum Data Set*, or *MDS*). This compatibility fosters and promotes continuity of care through a *seamless* assessment system across multiple facility-based and home and community-based settings.

The LOCET screening tool is primarily administered over the telephone by trained Long Term Care (LTC) Access contractor staff. The LTC Access contractor serves as the single point of entry for all individuals calling for admission to certain OAAS operated HCBS programs or nursing facility services.

This concept and use of the LOCET screening tool is designed to meet the following primary functions:

- Provide individuals, their caregivers, and their families comprehensive and objective information about community services, and program eligibility criteria that facilitates informed choices;
- Assist with navigation, linking consumers with the opportunities, services, and resources available to help meet their particular needs;
- Consistent delivery of a streamlined NFLOC screening process that fosters a person centered approach, and facilitates appropriate access to care;
- Streamline consumers’ transitions along the continuum of care; and
- Reduce barriers to accessing health care services and improve care delivery in a cost-effective and efficient manner.

The information required on the LOCET must be provided by the individual requesting services, or by someone who is sufficiently familiar with the individual to provide all required information, completely and accurately (e.g., self, responsible representative, family, nursing facility staff, hospital discharge planner staff, etc.).

The telephone-administered LOCET renders a “presumptive” NFLOC eligibility status. This means that the individual is *assumed* to meet at least one (1) of the NFLOC pathways described in Section 5.0, or via application of Degree of Difficulty Questions (DDQs) described below, as indicated by the LOCET screening results. The presumptive LOCET screening results are *verified by OAAS or its designees* within state and federal rules and regulations.

OAAS Participant Tracking System (OPTS) LOCET User Manual, as well as the LOCET form itself, include step-by-step instructions and stipulate the specified look-back periods in which to measure the individuals' abilities.
6.2 The Resident Assessment Instrument (RAI), Minimum Data Set-Home Care (MDS-HC)

The RAI, MDS-HC is a scientifically-validated and reliability-tested comprehensive and standardized instrument for evaluating the needs, strengths, and preferences of elders and adults with disabilities. The RAI, MDS-HC has been designed to be compatible with the congressionally-mandated MDS used in nursing facilities in the United States and several countries abroad. Such compatibility promotes continuity of care through a seamless assessment system across multiple health care settings, and promotes a person-centered evaluation.

The RAI, MDS-HC consists of the Minimum Data Set for Home Care (MDS-HC) and the Client Assessment Protocols (CAPs).

- The Minimum Data Set for Home Care (MDS-HC) is the assessment component that enables a home care provider to assess multiple key domains of function, health, social support, and service use. Particular assessment items also identify individuals who could benefit from further evaluation of specific problems and risks for functional decline. These items, known as “triggers,” link the assessment outcomes to a series of problem-oriented CAPs.

- The Client Assessment Protocols (CAPs) focus on an individual’s function and quality of life, assessing the his/her needs, strengths and preferences. CAPs are utilized in the care planning process, and facilitate referrals when appropriate. When used on multiple occasions (e.g., upon re-assessment), the CAPs provide the basis for an outcome-based assessment of the individual’s response to care or services.

The MDS-HC assessment tool is administered by OAAS trained and certified assessors in accordance with OAAS policies and procedures to verify that an individual meets the NFLOC eligibility criteria in at least one (1) of the NFLOC Pathways described in Section 5.0, or via application of Degree of Difficulty Questions (DDQs) described in Section 8.0 of this manual.

Some of the primary functions of the MDS-HC assessment process include:

- Verification of the presumptive LOCET screening results obtained by trained Long Term Care Access staff during the initial, telephone intake process, and;

- Verification that the individual continues to meet the required functional/medical NFLOC eligibility criteria upon subsequent re-
assessments (e.g., annual, follow up, status change re-
assessments, etc.).

All staff completing MDS-HC assessments must be trained and certified by OAAS. Certification is for a three (3) year period with annual refresher courses in accordance with OAAS’ Mandatory Certification policy and procedures.

In the interest of quality assurance, OAAS staff may require completion of another assessment by the same assessor under review, another staff member and/or OAAS staff themselves. In these situations, OAAS makes the final determination regarding whether or not the individual meets the required NFLOC eligibility criteria based on the assessment results and supporting documentation, as applicable.

7.0 LOCET NFLOC Review Process

The LOCET is coded to systematically determine NFLOC based on an algorithm developed. The LOCET results are automatically generated in the OPTS system based on the answers provided to the various pathway questions.

In the event the OPTS system is not readily available, OAAS and/or its designee must review the pathways in the same order as noted in the OPS system.

7.1 LOCET and DDQs

The LOCET also takes into consideration the Degree of Difficulty (DDQ) process. DDQ is determined based on the degree of difficulty an individual may be experiencing in completion of the ADLs at the time of the LOCET. DDQs are automatically displayed on the ADL screen section of the automated LOCET when an individual’s response equals a code of “Independent” on any of the ADLs. LTC Access contractor intake staff are prompted to ask if the individual has difficulty in the completion of that particular ADL. If the individual response is “Yes,” an additional set of questions appear on the LOCET screen. An example of how this item appears as follows:

If an individual is coded as “Independent” on the LOCET for the ADL of Toilet Use. The LOCET screen displays: *Do you have trouble with using the toilet?* If the LTC Access staff selects a response of “Yes,” the following set of questions appear on the LOCET screen, and the staff must ask and determine the most appropriate answer from the selection shown below:

I have a little difficulty, or
I have a lot of difficulty

OAAS Participant Tracking System (OPTS) contains an enhanced version of the LOCET that enables this information to be used in the final NFLOC determination process as applicable. If an individual indicates they have a lot of difficulty on one (1) of the late-loss ADLs, the individual is determined to meet NFLOC on the ADL pathway.

8.0 MDS-HC NFLOC Review Process

The intent of this section of the manual is to provide a detailed overview of the process that shall be utilized by all certified MDS-HC assessors when determining if an applicant/participant meets the functional/medical Level of Care eligibility criteria on initial and redetermination MDS-HC assessments.

8.1 Face-to-Face MDS-HC

The certified assessor completes a face-to-face MDS-HC assessment, in accordance with programmatic guidelines, as part of the initial intake process for individuals applying for HCBS programs, or for individuals undergoing a NFLOC re-assessment.

Once the assessor has completed the assessment, he/she must systematically review the data to verify that the individual meets NFLOC eligibility criteria.

8.2 MDS-HC NFLOC Review

- Review the (3) permanent pathways (ADL, Cognitive Performance, and Behavior pathways). “Triggered” or “Did Not Trigger” pathways will be automatically displayed in the MDS assessment software and may be printed as part of the CAPS Report.

- For initial assessments ONLY, review the Degree of Difficulty Questions (DDQs) for ADLs in section 8.3 of the manual.

  NOTE: DDQs are not reviewed for annual re-assessments, status changes, or follow-up assessments.

- Review Service Dependency. Assessors should utilize all LDH and contractor systems available. Assessors may require the assistance of OAAS Regional Office or State Office staff if he/she cannot verify that the individual was receiving services in a Medicaid nursing facility, or a HCBS program prior to 12/01/2006 with no break in services up to the present time.
• Review the temporary pathways (Skilled Rehabilitation, Treatments and Conditions, and Physician Involvement pathways). The assessor may need to probe further and review additional documentation to determine whether one (1) of the pathways is “triggered” with regard to NFLOC criteria and OAAS policy.

• Review all appropriate documentation and request any documentation deemed necessary.

• Determine NFLOC. Assessors should reflect the NFLOC time periods and information outlined in the NFLOC rule and OAAS policy and not necessarily the information outlined in the assessment tool alone.

• Ensure notebook entries reflect the NFLOC determination and rationale regarding the decision.

• Care plan if applicable.

8.3 DDQ Process for Initial MDS-HC Assessments

For late-loss ADLs where a “0” was coded on the MDS-HC, while conducting the face to face assessment, ask the participant, “Do you have trouble with ________?” Fill in the ADL activity noted below.

- Positioning yourself in bed (Mobility in Bed): (including moving to and from lying position, turning from side to side, and positioning body while in bed);

- Eating: (including taking in food by any method, including tube feeding - how person actually consumes food - excludes meal preparation);

- Transferring: from one surface to another (including moving to and between surfaces – to/from bed, chair wheelchair, standing position – excludes to/from bath/toilet); and

- Using the toilet (Toilet Use): (including using the toilet or commode, bedpan, urinal, transferring on/off the toilet, cleaning self after toilet use or incontinent episode, changing pad, managing special devices required (ostomy or catheter), and adjusting clothes.

If the participant responds “yes” to any of the items above, ask the participant if he/she has:

1. A little difficulty?
2. A lot of difficulty?

*A response of – “I have a lot of difficulty,” will indicate the person meets the NFLOC ADL pathway via application of the DDQs.
Examples of “a little difficulty” would be scenarios where the person is completing the ADL, but may have some pain, weakness or must compensate by using furniture or assistive devices to steady him/herself. Some examples are as follows:

- “I use the bathroom by myself OK, but sometimes I have a hard time getting up to a standing position again afterwards. However, I manage OK.”
- “I can use the bathroom OK, but I don’t quite make it sometimes.” A good follow up question: “Do you get your clothing wet or just damp?” If the response is “It’s damp”, code as “a little difficulty”.
- “I can sit up in bed by myself, but it takes me a little while to get my pillows just right to keep myself supported.”
- “I can turn myself in bed, but my hip hurts me a little if I move too fast.”
- “I can feed myself alright, but I drop food sometimes. “I’m just messy, I guess.” A good follow-up question: “Have you lost weight unintentionally in the last 6 months?” If the response is “No”, code “a little difficulty”.
- “I can get up from my chair OK, but I have to hold onto the arms of the chair for support because my legs don’t have the strength they used to.”
- “I can get up from my chair, but I have to rock myself back and forth a couple of times to get up because I don’t have a lot of strength in my legs.”
- “I can get out of bed OK, but I have to steady myself on the chair that’s beside the bed.”
- “When I go from my bed to a chair, it hurts a little when I bend my knees to sit on a low chair, so I try to use a straight back, higher chair to help me with this.”

Examples of “a lot of difficulty” would be scenarios where the individual is getting the ADL done, but with marked pain, or failure to complete all of the subtask in the particular ADL, or completion of the ADL in an extended period of time because of medical limitations (e.g., shortness of breath, moderate to extreme pain, exhaustion due to physical/medical limitations, etc.). Some examples are as follows:
“I use the bathroom by myself, but sometimes I cannot get up to a standing position again afterwards because of the pain. I end up waiting a long time between visits to the bathroom because of this.”

“I can use the bathroom OK, but I don’t make it sometimes.” A good follow up question: Do you get your clothing wet or just damp? If the response is “It’s wet”, code as “a lot of difficulty”.

“I can sit up in bed by myself, but it takes me a long time to move myself to do this. I just don’t have the strength anymore.”

“I can sit up in bed by myself, but when I try to do it, I end up with a coughing spell. That happens when I exert myself.”

“I can turn myself in bed if I do it really slowly because of the bad pain I get in my hip and back, especially when my pain medication has worn off.”

“I feed myself, but my hands are so shaky now, it takes me twice as long as it used to because I continually drop food.” A good follow-up question: “Have you lost weight unintentionally in the last 6 months?” If the response is “Yes”, code as “a lot of difficulty”.

“I can get up from my chair, but I am winded by the time I can finally stand up. I am really weak.”

“I can get out of bed some of the time, but I have slipped and fallen before because I am unsteady and weak.”

“It takes me several minutes or so to lower myself into my chair to watch TV. The arthritis in my back is just too painful.”

### 8.3.1 Documentation of DDQ Results in the MDS-HC Notebook

Documentation must be recorded in the MDS-HC electronic “Notebook” section.

Documentation must include:
- Observations/comments on which you based your decision to use the DDQs.
- The individual’s response to the DDQs.
- A statement indicating the client has met NFLOC eligibility criteria on the ADL pathway via the application of DDQs.

**NOTE:** Do NOT CHANGE the original ADL score of “0”, Independent, for the late-loss ADLs where DDQs are applied. The documentation to the
Notebook will suffice as verification that the persons has met the NFLOC on the ADL pathway via application of the DDQ process.

9.0 NFLOC when Transitioning Between Programs
This section describes general NFLOC policies governing transitioning between HCBS programs, from nursing facilities to HCBS and from hospitals to HCBS. Specific program requirements are not addressed in this manual, therefore, program manuals should be referenced as needed.

9.1 Transitioning Between HCBS Programs
If an individual transfers from one HCBS to another then a new MDS-HC assessment must be completed.

9.2 Transitioning Out of a Nursing Facility to HCBS
Individuals transitioning from a nursing facility to an OAAS HCBS program identified in this manual must meet functional/medical NFLOC eligibility requirements as determined by the MDS-HC assessment.

The MDS-HC is performed prior to the individual transitioning out of the nursing facility. The assessment is used as a means of assuring the individual meets NFLOC, to assure that he/she can safely transition to the HCBS of his/her choice, and for the development of an individualized Plan of Care (POC) that considers the individual’s choices and preferences.

All program requirements must be met and the proper protocols must be followed to assure that the individual will continue to meet NFLOC once he/she transitions from the nursing facility to the community. (Refer to program policy manuals for specific procedures which are to be followed regarding verification of continued Medicaid financial eligibility post transition from nursing facility to the community).

These individuals will be required to meet NFLOC upon initial assessment and re-assessment, as specified in state program and federal rules and regulations.

9.3 Transitioning from a Hospital to HCBS
9.3.1 Transitioning from a Hospital to ADHC
Individuals who are hospitalized at the time they call the contracted LTC Access contractor and who wish to transition from the hospital setting to an ADHC Waiver may do so if:

- They have had at least one (1) overnight stay in a hospital within the prior 30 days;

- There is an ADHC Waiver slot available;
• They meet functional/medical NFLOC eligibility via the MDS-HC; and

• They meet ADHC Waiver program requirements.

9.3.2 Transitioning from a Hospital to LT-PCS

Individuals who are hospitalized at the time they call the LTC Access contractor, and who wish to access LT-PCS must:

• Already be Medicaid eligible at the time of the initial SPOE contact;

• Meet NFLOC eligibility on the LOCET screening tool;

• Be assessed via the MDS-HC in their home environment (i.e. place of residence) once they exit the hospital setting;

• Meet NFLOC verification on the MDS-HC; and

• Meet all LT-PCS specific program requirements that includes limited assistance in one (1) ADL and Initial Targeting Criteria.

9.4 Transitioning from a Hospital to a Nursing Facility

Individuals wishing to transition from a hospital setting as a new admission to a nursing facility setting must:

• Meet NFLOC eligibility on the LOCET;

• Complete the Pre Admission Screening and Resident Review (PASRR) Level I, and meet its requirements prior to being admitted in to the nursing facility;

• Continue to meet NFLOC requirements per state and federal rules and regulations.

Individuals that are hospitalized while a resident in a nursing facility must continue to meet NFLOC requirements in order to remain in the nursing facility. In this instance, these individuals may be assessed for continued nursing facility stay if there has been a significant change in status and the following must occur:

• The nursing facility must contact OAAS Nursing Facility Admission (NFA) unit or the Level II authorities (OBH if the individual has a mental illness or OCDD if the individual has an intellectual/developmental disability) for a continued stay determination.
9.5 HCBS Participant Transitioning from the Community Setting to a Nursing Facility

Individuals who are currently receiving OAAS HCBS Waiver services, LT-PCS, or PACE services **do NOT require a LOCET screening** in order to transition to a nursing facility.

These individuals are determined to meet the required NFLOC eligibility criteria **via the MDS-HC NFLOC verification process for HCBS**. However, in accordance with state and federal requirements, a PASRR Level I and if applicable a PASRR Level II must be completed by the admitting nursing facility **PRIOR** to the individual being admitted to the nursing facility of his/her choice.

Individuals transitioning from the community setting to a nursing facility may be approved for time-limited stays, per state and federal rules and regulations.

10. Special Considerations for Specific Programs

10.1 LT-PCS

10.1.1 LT-PCS and DDQs

Individuals who meet NFLOC criteria on the ADL pathway via application of the DDQ process will also be determined to meet LT-PCS programmatic criteria.

10.1.2 LT-PCS and Initial Targeting Criteria

Initial Targeting Criteria (ITC) is considered met if the individual meets the criteria listed below:

- Is in a nursing facility and could be discharged if community-based services were available; or
- Is likely to require nursing facility admission within the next 120 days; or
- Has a primary care giver who has a disability or is age 70 or over.

ITC is **ONLY** for initial assessments for **BOTH** LOCET and MDS-HC.

In order to determine ITC:

- Review for institutional risk criteria and current nursing facility placement.
  - If the individual is currently in a nursing facility or determined by LOCET or the MDS-HC/ITC crosswalk to meet institutional risk then the individual meets ITC.
  - If the individual is not in a nursing facility and does not meet institutional risk criteria then the individual is mailed a
“Request for More Information” or Medical Deterioration (MedDet) form that the individual's physician must complete for institutional risk verification. Individuals have 30 calendar days to return the form back to OAAS or its designee.

- If the information is returned, the form will be reviewed to determine if the individual is likely to require nursing facility admission within the next 120 days.
  - If “No”, then ITC is NOT MET and the individual is denied.
  - If “Yes”, then ITC is MET.
- If the information is not returned then the individual will be determined to not meet ITC.

- OAAS or its designee must also verify the primary care giver disability and age of the individual applying for services. In this instance, the individual has 30 calendar days in order to return this information. If this information is not received within this time period, then the individual is considered to not meet ITC and denied services.

10.2 PACE

Individuals wishing to access PACE services must initially meet NFLOC eligibility criteria in order to enroll in that program. If, upon annual reassessment, the individual fails to meet the NFLOC there is another eligibility option available ONLY to PACE participants. This process is referred to as “Deeming Continued Eligibility” and is based on criteria as follows:

- The participant no longer meets NFLOC criteria but would reasonably be expected to become eligible within six (6) months in the absence of continued coverage under the program.

- The participant's medical record and Plan of Care (POC) support deemed continued eligibility.

For additional information regarding PACE please refer to the PACE manual.
APPENDIX A

LAC 50: II (10154& 10156)
Subchapter G. Levels of Care

§10154. Nursing Facility Level of Care Determinations

A. The purpose of the level of care (LOC) determination is to assure that individuals meet the functional and medical necessity requirements for admission to and continued stay in a nursing facility. In addition, the LOC determination process assists persons with long-term or chronic health care needs in making informed decisions and selecting options that meet their needs and reflect their preferences.

B. In order for an individual to meet nursing facility level of care, functional and medical eligibility must be met as set forth and determined by the Office of Aging and Adult Services (OAAS). The functional and medical eligibility process is frequently referred to as the “nursing facility level of care determination.”

C. OAAS shall utilize prescribed screening and assessment tools to gather evaluation data for the purpose of determining whether an individual has met the nursing facility level of care requirements as set forth in this Subchapter.

D. Individuals who are approved by OAAS, or its designee, as having met nursing facility level of care must continue to meet medical and functional eligibility criteria on an ongoing basis.

E. A LOC screening conducted via telephone shall be superseded by a face-to-face minimum data set (MDS) assessment, minimum data set for home care (MDS-HC) assessment, or audit review LOC determination as determined by OAAS or its designee.

F. If on an audit review or other subsequent face-to-face LOC assessment, the LOC findings are determined to be incorrect or it is found that the individual no longer meets level of care, the audit or subsequent face-to-face LOC assessment findings will prevail.

G. The department may require applicants to submit documentation necessary to support the nursing facility level of care determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:2083 (November 2006), amended by the Office of Aging and Adult Services, LR 34:1032 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:341 (January 2011), LR 39:1471 (June 2013).
§10156. Level of Care Pathways

A. Several potential avenues of functional and medical eligibility shall be investigated by OAAS. These avenues are called pathways. The pathways are utilized to ensure consistency, uniformity, and reliability in making nursing facility level of care determinations. In order to meet the nursing facility level of care, an individual must meet eligibility requirements in only one pathway.

B. When specific eligibility criteria are met within a pathway, that pathway is said to have triggered. The Medicaid program defines nursing facility level of care for Medicaid eligible individuals as the care required by individuals who meet or trigger any one of the established level of care pathways described in this Subchapter. The pathways of eligibility focus on information used to determine if an individual has met or triggered a level of care pathway.

C. The level of care pathways elicit specific information, within a specified look-back period, regarding the individual’s:

1. functional capabilities;
2. receipt of assistance with activities of daily living (ADL);
3. current medical treatments and conditions; and
4. other aspects of an individual’s life.

D. Activities of Daily Living Pathway

1. The intent of this pathway is to determine the individual’s self-care performance in activities of daily living during a specified look-back period (e.g., the last seven days, last three days, etc. from the date the LOC assessment was completed) as specified in prescribed screening and assessment tools.

2. The ADL Pathway identifies those individuals with a significant loss of independent function measured by the amount of assistance received from another person in the period just prior to the day the LOC assessment was completed.

3. The ADLs for which the LOC assessment elicits information are:

a. locomotion—moving around in the individual’s home;

b. dressing—how the individual dresses/undresses;

c. eating—how food is consumed (does not include meal preparation);

d. bed mobility—moving around while in bed;

e. transferring—how the individual moves from one surface to another (excludes getting on and off the toilet and getting in and out of the tub/shower);

f. toileting—inclues getting on and off the toilet, wiping, arranging clothing, etc.;

g. personal hygiene (excludes baths/showers); and

h. bathing (excludes washing of hair and back).

4. Since an individual can vary in ADL performance from day to day, OAAS trained assessors shall capture the total picture of ADL performance over the specified look-back period.

5. In order for an individual to be approved under the ADL Pathway, the individual must score at the:

a. limited assistance level or greater on toilet use, transferring, or bed mobility; or

b. extensive assistance level or greater on eating.

E. Cognitive Performance Pathway.

1. This pathway identifies individuals with the following cognitive difficulties:

a. short term memory which determines the individual’s functional capacity to remember recent events;

b. cognitive skills for daily decision making which determines the individual’s actual performance in making everyday decisions about tasks or activities of daily living such as:

i. planning how to spend his/her day;

ii. choosing what to wear; or

iii. reliably using canes/walkers or other assistive devices/equipment, if needed;

c. making self understood which determines the individual’s ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

2. In order for an individual to be approved under the cognitive performance pathway, the individual must have any one of the conditions noted below:

a. be severely impaired in daily decision making (never or rarely makes decisions);

b. have a short term memory problem and daily decision making is moderately impaired (e.g., the individual’s decisions are consistently poor or unsafe, cues or supervision is required at all times);

c. have a memory problem and is sometimes understood (e.g., the individual’s ability is limited to making concrete requests);

d. have a short-term memory problem and is rarely or never understood;

e. be moderately impaired in daily decision making (e.g., the individual’s decisions are consistently poor or unsafe, cues or supervision is required at all times) and the individual is usually understood (e.g., the individual has...
difficulty finding words or finishing thoughts and prompting may be required);

f. be moderately impaired in daily decision making (e.g., the individual’s decisions are consistently poor or unsafe, cues or supervision is required at all times) and the individual is sometimes understood, (e.g., his/her ability is limited to making concrete requests);

g. be moderately impaired in daily decision making (e.g., the individual’s decisions are consistently poor or unsafe, cues or supervision is required at all times) and the individual is rarely or never understood;

h. be minimally impaired in daily decision making (e.g., the individual has some difficulty in new situations or his/her decisions are poor and requires cues and supervision in specific situations only) and the individual is sometimes understood (e.g., the individual’s ability is limited to making concrete requests); or

i. be minimally impaired in daily decision making (e.g., the individual has some difficulty in new situations or his/her decisions are poor, cues and supervision are required in specific situations only) and the individual is rarely or never understood.

F. Physician Involvement Pathway

1. The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting a person’s ability to care for himself/herself.

2. The following are investigated for this pathway:
   a. stage 3-4 pressure sores during the 14-day look-back period;
   b. intravenous feedings during the 7-day look-back period;
   c. intravenous medications during the 14-day look-back period;
   d. daily tracheostomy care and ventilator/respiratory suctioning during the 14-day look-back period;
   e. pneumonia during the 14-day look-back period and the individual had associated need for assistance with IADLs, ADLs, or restorative nursing care;
   f. daily respiratory therapy provided by a qualified professional during the 14-day look-back period;
   g. daily insulin injections with two or more order changes during the 14-day look-back period; or
   h. peritoneal or hemodialysis during the 14-day look-back period.

3. In order for an individual to be approved under the treatments and conditions pathway, the individual must have:
   a. any one of the conditions listed in G.2.a-h above; and
   b. supporting documentation for the specific condition(s) identified. Acceptable documentation must include:
      i. a copy of the physician’s orders; or
      ii. the home health care plans documenting the diagnosis, treatments and conditions within the designated time frames; or
      iii. the appropriate form designated by OAAS to document the individual’s medical status and condition.

4. This pathway is approved for limited stay/length of service as deemed appropriate by OAAS.

H. Skilled Rehabilitation Therapies Pathway

1. The intent of this pathway is to identify individuals who have received, or are scheduled to receive physical therapy, occupational therapy or speech therapy.

2. In order for an individual to be approved under this pathway, the individual must:
   a. have received at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy during the seven-day look-back period; or
   b. be scheduled to receive at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy scheduled during the seven-day look-forward period.
3. Supporting documentation of the therapy received/scheduled during the look-back/look-forward period is required and must include:

   a. a copy of the physician’s orders for the received/scheduled therapy;
   b. the home health care plan notes indicating the received/scheduled therapy;
   c. progress notes indicating the physical, occupational, and/or speech therapy received;
   d. nursing facility or hospital discharge plans indicating the therapy received/scheduled; or
   e. the appropriate form designated by OAAS to document the individual’s medical status and condition.

4. This pathway is approved for limited stay/length of service as deemed appropriate by OAAS.

I. Behavior Pathway

1. The intent of this pathway is to identify individuals who have experienced repetitive behavioral challenges which have impacted his/her ability to function in the community during the specified screening/assessment look-back period.

2. The following are investigated for this pathway:
   a. wandering;
   b. verbally- or physically-abusive behavior;
   c. socially-inappropriate behavior; and
   d. delusions or hallucinations.

3. In order for an individual to be approved under the behavior pathway, the individual must have either:

   a. exhibited any one of the following behaviors four or more days of the screening tool’s seven-day look-back period:
      i. wandering;
      ii. verbally abusive;
      iii. physically abusive; or
      iv. socially inappropriate or disruptive; or
   b. exhibited any one of the following behaviors during the assessment tool’s three-day look-back period and behavior(s) were not easily altered:
      i. wandering;
      ii. verbally abusive;
      iii. physically abusive; or
      iv. socially inappropriate or disruptive; or
   c. experienced delusions or hallucinations that impacted his/her ability to live independently in the community within the specific screening/assessment tool’s look-back period.

J. Service Dependency Pathway

1. The intent of this pathway is to identify individuals who are currently in a nursing facility or receiving services through the Adult Day Health Care Waiver, the Community Choices Waiver, Program of All Inclusive Care for the Elderly (PACE) or receiving long-term personal care services.

2. In order for individuals to be approved under this pathway, the afore-mentioned services must have been approved prior to December 1, 2006 and ongoing services are required in order for the individual to maintain current functional status.

3. There must have been no break in services during this time period.

  AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

APPENDIX B-Descriptions of NFLOC
(LOCET, MDS-HC Community, MDS-HC Nursing Facility Residents)
A person needs to meet only 1 of the following 7 pathways. If 1 pathway is met, then the person meets nursing facility level of care.

1. **Activities of Daily Living (ADL) Pathway:**

This pathway looks at certain help a person got in the 7 days before the assessment. If the person needed help but no one was there to help, this will be considered.

For a person to meet the ADL pathway, the person must have gotten help with a “late-loss ADL” by getting **EITHER**:

- **“Limited assistance”** or more help with one of the following. Someone else helped to guide or move the person’s arms or legs, or gave other hands on help (3) or more times during the 7 days before the assessment in:
  
  - **Toilet Use** - Using the toilet, commode, bedpan, or urinal; sitting down or getting up off the toilet; cleaning self after using the toilet; cleaning self after having an incontinent episode; managing any special devices like an ostomy or catheter; and adjusting clothes after using the toilet.
  
  - **Bed Mobility** - Moving around while in bed. Moving to and from a lying position, turning from side to side, sitting up in bed to stay in bed, and positioning body while in bed.
  
  - **Transferring** – Moving from one surface to another such as to and from bed, chair, wheelchair, or standing/sitting position.

  OR

- **“Extensive assistance”** or more help with eating (including tube feeding). Someone else had to actually feed the person 3 or more times during the 7 days before the assessment. This does not include preparing food.

2. **Cognitive Performance Pathway:**

This pathway looks at a person’s memory of things that just happened. It also looks at how well a person makes everyday decisions about things like planning how to spend the day, choosing clothing, or using canes or walkers, if needed; and the ability to make needs, opinions, and wants understood by others.
For a person to meet this pathway, the person must be:

- “Severely impaired” in daily decision making (never or rarely makes decisions); OR

- “Moderately impaired” in decision making (decisions are usually poor or unsafe, cues or supervision are always needed) and is “usually”, “sometimes”, or “rarely/never understood” (the person has difficulty finding words or finishing thoughts and prompting may be required, or they only make concrete requests); OR

- “Minimally impaired” in decision making (some problems in new situations or decisions are poor and only requires supervision sometimes) and is “sometimes understood” (makes only concrete requests) or “rarely/never understood”; OR

- Have a “memory problem” such as a problem recalling recent events and is “moderately impaired” in decision making (decisions are usually poor or unsafe, cues or supervision always needed); OR

- Have a “memory problem” such as a problem recalling recent events and is “sometimes understood” (makes only concrete requests) or “rarely/never understood”.

3. Physician Involvement Pathway:

This pathway looks at unstable medical conditions that may affect the ability to care for oneself. Doctor visits and doctor orders are reviewed for this pathway. A person that meets this pathway could get a short-term approval.

For a person to meet this pathway, he/she must have:

- Visited the doctor on 1 day (other than an emergency room visit) and gotten at least 4 changes in doctor’s orders (other than order renewals without change or orders made while a patient in the hospital) in the 14 days before the assessment; or

- Visited the doctor on 2 days (other than an emergency room visit) and gotten at least 2 changes in doctor’s orders (other than order renewals without change or orders made while a patient in the hospital) in the 14 days before the assessment;

**WITH:**

- Supporting documents, such as: (a) a copy of the doctor’s orders, (b) the home health care plan showing the diagnosis, treatments and conditions with dates showing when the visits and orders were done, or (c) an OAAS form with the person’s medical status and condition.
4. Treatments and Conditions Pathway:

This pathway looks at unstable medical conditions that may affect the ability to care for oneself. A person that meets this pathway could get a short-term approval.

For a person to meet this pathway, the person must have

- Intravenous (IV) feedings in the 7 days before the assessment; or

In the 14 days before the assessment:

- Stage 3-4 pressure sores; or
- Intravenous (IV) medications; or
- Daily tracheostomy care and ventilator/ventilator suctioning; or
- Pneumonia and the person needed help from others during this time; or
- Daily respiratory therapy provided by a qualified professional; or
- Daily insulin injections with two or more order changes; or
- Peritoneal or hemodialysis.

WITH:

Supporting documents, such as: (a) a copy of the doctor’s orders, (b) the home health care plan with the diagnosis, treatments and conditions within the designated timeframes, or (c) an OAAS form with the person’s medical status and condition.

5. Skilled Rehabilitation Therapies Pathway

This pathway looks at a person who has had, or who is scheduled to get, physical therapy, occupational therapy, or speech therapy. A person that meets this pathway could get a short-term approval.

For a person to meet this pathway, the person must have:

- Had at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy in the 7 days before the assessment; **OR**

- Have at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy scheduled during the 7 days after the assessment.

**WITH:**
• Supporting documents, such as: (a) a copy of the doctor’s orders for the scheduled therapy, (b) the home health care plan notes showing that the therapy was received or is scheduled, (c) progress notes showing that the physical, occupational, and/or speech therapy is received or scheduled, (d) nursing facility or hospital discharge plans showing that the therapy is received or scheduled or (e) an OAAS form with the person’s medical status and condition.

6. Behavior Pathway:

This pathway is for a person who has had repeated behavioral issues that affect his/her ability to function in the community in the 7 days before his/her assessment.

For a person to meet this pathway, one of the following must have happened to the person on (4) or more days during the 7 day period before the assessment:

• Had wandering, verbally or physically abusive, or socially inappropriate or disruptive behavior AND the behavior was not easily altered; OR

• Had delusions or hallucinations that impacted their ability to live independently in the community.

7. Service Dependency Pathway:

This pathway is for a person who has been continuously approved for and receiving either waiver, nursing facility services, LongTerm-Personal Care Services (LT-PCS), or Program of All Inclusive Care for the Elderly (PACE) services since December 1, 2006. There must have been no break in services during this time period and the person must require continued services in order to maintain his/her current functional status.
Description of Nursing Facility Level of Care Pathways for Minimum Data Set-Home Care (MDS-HC)

A person needs to meet only 1 of the following 7 pathways. If 1 pathway is met, then the person meets nursing facility level of care.

1. Activities of Daily Living (ADL) Pathway:

This pathway looks at certain help a person got in the 3 days before the assessment. If the person needed help but no one was there to help, this will be considered.

For a person to meet the ADL pathway, the person must have gotten help with a "late-loss ADL" by getting EITHER:

- **"Limited assistance"** or more help with one of the following. Someone else helped to guide or move the person’s arms or legs, or gave other hands on help 3 or more times during the 3 days before the assessment in:
  - **Toilet Use** - Using the toilet, commode, bedpan, or urinal; sitting down or getting up off the toilet; cleaning self after using the toilet; cleaning self after having an incontinent episode; managing any special devices like an ostomy or catheter; and adjusting clothes after using the toilet.
  - **Bed Mobility** - Moving around while in bed. Moving to and from a lying position, turning from side to side, sitting up in bed to stay in bed, and positioning body while in bed.
  - **Transferring** – Moving from one surface to another such as to and from bed, chair, wheelchair, or standing/sitting position.

OR

- **"Extensive assistance"** or more help with eating (including tube feeding). Someone else had to actually feed the person 3 or more times during the 3 days before the assessment. This does not include preparing food.

2. Cognitive Performance Pathway:

This pathway looks at a person’s memory of things that just happened. It also looks at how well a person makes everyday decisions about things like planning how to spend the day, choosing clothing, or using canes or walkers, if needed; and the ability to make needs, opinions, and wants understood by others.
For a person to meet this pathway, the person must be:

- **“Severely impaired”** in daily decision making (never or rarely makes decisions); OR

- **“Moderately impaired”** in decision making (decisions are usually poor or unsafe, cues or supervision are always needed) and is “usually”, “sometimes”, or “rarely/never understood” (the person has difficulty finding words or finishing thoughts and prompting may be required, or they only make concrete requests); OR

- **“Minimally impaired”** in decision making (some problems in new situations or decisions are poor and only requires supervision sometimes) and is “sometimes understood” (makes only concrete requests) or “rarely/never understood”; OR

- Have a “memory problem” such as a problem recalling recent events and is “moderately impaired” in decision making (decisions are usually poor or unsafe, cues or supervision always needed); OR

- Have a “memory problem” such as a problem recalling recent events and is “sometimes understood” (makes only concrete requests) or “rarely/never understood”.

3. **Physician Involvement Pathway:**

This pathway looks at unstable medical conditions that may affect the ability to care for oneself. Doctor visits and doctor orders are reviewed for this pathway. A person that meets this pathway could get a short-term approval.

For a person to meet this pathway, he/she must have:

- Visited the doctor on 1 day (other than an emergency room visit) and gotten at least 4 changes in doctor’s orders (other than order renewals without change or orders made while a patient in the hospital) in the 14 days before the assessment; or

- Visited the doctor on 2 days (other than an emergency room visit) and gotten at least 2 changes in doctor’s orders (other than order renewals without change or orders made while a patient in the hospital) in the 14 days before the assessment;

**WITH:**

- Supporting documents, such as: (a) a copy of the doctor’s orders, (b) the home health care plan showing the diagnosis, treatments and conditions with dates
4. Treatments and Conditions Pathway:

This pathway looks at unstable medical conditions that may affect the ability to care for oneself. A person that meets this pathway could get a short-term approval.

For a person to meet this pathway, the person must have

- Intravenous (IV) feedings in the 7 days before the assessment; or

In the 14 days before the assessment:

- Stage 3-4 pressure sores; or
- Intravenous (IV) medications; or
- Daily tracheostomy care and ventilator/respiratory suctioning; or
- Pneumonia and the person needed help from others during this time; or
- Daily respiratory therapy provided by a qualified professional; or
- Daily insulin injections with two or more order changes; or
- Peritoneal or hemodialysis.

WITH:

- Supporting documents, such as: (a) a copy of the doctor’s orders, (b) the home health care plan with the diagnosis, treatments and conditions within the designated timeframes, or (c) an OAAS form with the person’s medical status and condition.

5. Skilled Rehabilitation Therapies Pathway:

This pathway looks at a person who has had, or who is scheduled to get, physical therapy, occupational therapy, or speech therapy. A person that meets this pathway could get a short-term approval.

For a person to meet this pathway, the person must have:

- Had at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy in the 7 days before the assessment; OR
• Have at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy scheduled during the 7 days after the assessment.

WITH:

• Supporting documents, such as: (a) a copy of the doctor’s orders for the scheduled therapy, (b) the home health care plan notes showing that the therapy was received or is scheduled, (c) progress notes showing that the physical, occupational, and/or speech therapy is received or scheduled, (d) nursing facility or hospital discharge plans showing that the therapy is received or scheduled or (e) an OAAS form with the person's medical status and condition.

6. Behavior Pathway:

This pathway is for a person who has had repeated behavioral issues that affect his/her ability to function in the community in the 3 days before his/her assessment.

For a person to meet this pathway, one of the following must have happened to the person at least once during the 3 day period before the assessment:

• Had wandering, verbally or physically abusive, or socially inappropriate or disruptive behavior AND the behavior was not easily altered; OR

• Had delusions or hallucinations that impacted their ability to live independently in the community.

7. Service Dependency Pathway:

This pathway is for a person who has been continuously approved for and receiving either waiver, nursing facility services, Long Term-Personal Care Services (LT-PCS), or Program of All Inclusive Care for the Elderly (PACE) services since December 1, 2006. There must have been no break in services during this time period and the person must require continued services in order to maintain his/her current functional status.
Description of Nursing Facility Level of Care Pathways for Nursing Facility Residents

A person needs to meet only 1 of the following 7 pathways. If 1 pathway is met, then the person meets nursing facility level of care.

1. Activities of Daily Living (ADL) Pathway:

This pathway looks at certain help a person got in the 7 days before the assessment. If the person needed help but no one was there to help, this will be considered.

For a person to meet the ADL pathway, the person must have gotten help with a “late-loss ADL” by getting EITHER:

- **“Limited assistance”** or more help with one of the following. Someone else helped to guide or move the person’s arms or legs, or gave other hands on help 3 or more times during the 7 days before the assessment in:
  
  o **Toilet Use** - Using the toilet, commode, bedpan, or urinal; sitting down or getting up off the toilet; cleaning self after using the toilet; cleaning self after having an incontinent episode; managing any special devices like an ostomy or catheter; and adjusting clothes after using the toilet.

  o **Bed Mobility** - Moving around while in bed. Moving to and from a lying position, turning from side to side, sitting up in bed to stay in bed, and positioning body while in bed.

  o **Transferring** – Moving from one surface to another such as to and from bed, chair, wheelchair, or standing/sitting position.

  **OR**

- **“Extensive assistance”** or more help with eating (including tube feeding). Someone else had to actually feed the person 3 or more times during the 7 days before the assessment. This does not include preparing food.

2. Cognitive Performance Pathway:

This pathway looks at a person’s memory of things that just happened. It also looks at how well a person makes everyday decisions about things like planning how to spend the day, choosing clothing, or using canes or walkers, if needed; and the ability to make needs, opinions, and wants understood by others.
For a person to meet this pathway, the person must:

- Be “**Severely impaired**” in daily decision making (never or rarely makes decisions); OR

- Be “**Moderately impaired**” in decision making (decisions are usually poor or unsafe, cues or supervision are always needed) and is “**usually**, “**sometimes**”, or “**rarely/ never understood**” (the person has difficulty finding words or finishing thoughts and prompting may be required, or they only make concrete requests); OR

- Be “**Minimally impaired**” in decision making (some problems in new situations or decisions are poor and only requires supervision sometimes) and is “**sometimes understood**” (makes only concrete requests) or “**rarely/never understood**”; OR

- Have a “**memory problem**” such as a problem recalling recent events and is “**moderately impaired**” in decision making (decisions are usually poor or unsafe, cues or supervision always needed); OR

- Have a “**memory problem**” such as a problem recalling recent events and is “**sometimes understood**” (makes only concrete requests) or “**rarely/never understood**”.

### 3. Physician Involvement Pathway:

This pathway looks at unstable medical conditions that may affect the ability to care for oneself. Doctor visits and doctor orders are reviewed for this pathway. A person that meets this pathway could get a short-term approval.

For a person to meet this pathway, he/she must have:

- Visited the doctor on 1 day (other than an emergency room visit) and gotten at least 4 changes in doctor’s orders (other than order renewals without change or orders made while a patient in the hospital) in the 14 days before the assessment; or

- Visited the doctor on 2 days (other than an emergency room visit) and gotten at least 2 changes in doctor’s orders (other than order renewals without change or orders made while a patient in the hospital) in the 14 days before the assessment;

**WITH:**

- Supporting documents, such as: (a) a copy of the doctor’s orders, (b) the home health care plan showing the diagnosis, treatments and conditions with dates showing when the visits and orders were done, or (c) an OAAS form with the person’s medical status and condition.
4. Treatments and Conditions Pathway:

This pathway looks at unstable medical conditions that may affect the ability to care for oneself. A person that meets this pathway could get a short-term approval.

For a person to meet this pathway, the person must have:

- Intravenous (IV) feedings in the 7 days before the assessment; or

In the 14 days before the assessment:

- Stage 3-4 pressure sores; or
- Intravenous (IV) medications; or
- Daily tracheostomy care and ventilator/respiratory suctioning; or
- Pneumonia and the person needed help from others during this time; or
- Daily respiratory therapy provided by a qualified professional; or
- Daily insulin injections with two or more order changes; or
- Peritoneal or hemodialysis.

WITH:

Supporting documents, such as: (a) a copy of the doctor's orders, (b) the home health care plan with the diagnosis, treatments and conditions within the designated timeframes, or (c) an OAAS form with the person’s medical status and condition.

5. Skilled Rehabilitation Therapies Pathway:

This pathway looks at a person who has had, or who is scheduled to get, physical therapy, occupational therapy, or speech therapy. A person that meets this pathway could get a short-term approval.

For a person to meet this pathway, the person must:

- Have had at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy in the 7 days before the assessment; OR
- Have at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy scheduled during the 7 days after the assessment.

WITH:
• Supporting documents, such as: (a) a copy of the doctor’s orders for the scheduled therapy, (b) the home health care plan notes showing that the therapy was received or is scheduled, (c) progress notes showing that the physical, occupational, and/or speech therapy is received or scheduled, (d) nursing facility or hospital discharge plans showing that the therapy is received or scheduled or (e) an OAAS form with the person’s medical status and condition.

6. Behavior Pathway:

This pathway is for a person who has had repeated behavioral issues that affect his/her ability to function in the community in the 3 days before his/her assessment.

For a person to meet this pathway, one of the following must have happened to the person at least once during the 3 day period before the assessment:

• Had wandering, verbally or physically abusive, or socially inappropriate or disruptive behavior **AND** the behavior was not easily altered; **OR**

• Had delusions or hallucinations that impacted their ability to live independently in the community.

7. Service Dependency Pathway:

This pathway is for a person who has been continuously approved for and receiving either waiver, nursing facility services, Long Term-Personal Care Services (LT-PCS), or Program of All Inclusive Care for the Elderly (PACE) services since December 1, 2006. There must have been no break in services during this time period and the person must require continued services in order to maintain his/her current functional status.