

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—includes 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 in a. through m. below:

§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) and instrumental activities of daily living (IADL);
- 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

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 short term memory problem and daily decision making is severely impaired (e.g., never or rarely makes decisions);

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

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

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 usually understood, (e.g., the individual has difficulty finding words or finishing thoughts and prompting may be required);

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 sometimes understood (e.g., his/her ability is limited to making concrete requests);

h. 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;

i. be severely impaired in daily decision making, never or rarely makes decisions. The individual has difficulty finding words or finishing thoughts and prompting may be required;

j. be severely impaired in daily decision making (e.g., never or rarely makes decisions) and the individual is sometimes understood (e.g., his/her ability is limited to making concrete requests);

k. be severely impaired in daily decision making, never or rarely makes decisions, and the individual is rarely or never understood;

l. 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

m. 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 his/her ability to care for himself/herself.

2. Physician visits and physician orders will be investigated for this pathway. Consideration will be given to the physician visits in the last 14 days, excluding emergency room exams, and physician orders in the last 14 days, excluding order renewals without change or hospital inpatient visits.

3. In order for an individual to be approved under the physician involvement pathway, the individual must have one day of doctor visits and at least four new order changes within the last 14 days and:

a. at least 2 days of doctor visits and at least two new order changes within the last 14 days; or

b. supporting documentation for the specific condition(s) identified and deemed applicable by OAAS. Acceptable documentation may include:

i. a copy of the physician's orders;

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.

G. Treatments and Conditions Pathway

1. The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself. The following treatments and conditions shall be investigated for this pathway:

a. stage 3-4 pressure sores in the last 14 days;

b. intravenous feedings in the last 7 days;

c. intravenous medications in the last 14 days;

d. daily tracheostomy care and ventilator/respiratory suctioning in the last 14 days;

e. pneumonia in the last 14 days and the individual's associated IADL or ADL needs or restorative nursing care needs;

f. daily respiratory therapy provided by a qualified professional in the last 14 days;

g. daily insulin injections with two or more order changes in the last 14 days;

i. supporting documentation shall be required for the daily insulin usage and the required order changes; and

h. peritoneal or hemodialysis in the last 14 days.

2. 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 §10156.G.1.a-h; and
- b. supporting documentation for the specific condition(s) identified and deemed applicable by OAAS. Acceptable documentation may include:
 - i. a copy of the physician's orders;
 - 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.

3. 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, at least 45 minutes of physical therapy, occupational therapy, or speech therapy in the last seven days or within seven days from the date the LOC assessment is completed.

2. In order for an individual to be approved under the skilled rehabilitation therapies pathway, the individual must have:

- a. received at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy during the last seven days; or
- b. at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy scheduled for the next seven days as specified in the applicable screening/assessment tool and supporting documentation for the specific condition(s) identified and deemed applicable by OAAS. Acceptable documentation may include:
 - i. a copy of the physician's orders for the scheduled therapy;
 - ii. the home health care plan notes indicating the therapy received during the required look-back period;
 - iii. progress notes indicating the physical, occupational, and/or speech therapy received or scheduled;
 - iv. nursing facility or hospital discharge plans indicating the therapy received for the required look-back period or therapy scheduled for the required look-forward period; or
 - v. the appropriate form designated by OAAS to document the individual's medical status and condition.

3. 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. The behavior challenges may include:

- a. wandering;
- b. verbally or physically abusive behavior;
- c. socially inappropriate behavior; or
- d. delusions or hallucinations.

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

a. exhibited any one of the following behaviors four to six days of the look-back period, but less than daily as specified in the prescribed screening/assessment tool:

- i. wandering;
- ii. verbally abusive;
- iii. physically abusive;
- iv. socially inappropriate or disruptive.

b. exhibited any one of the following behaviors daily:

- i. wandering;
- ii. verbally abusive;
- iii. physically abusive;
- iv. socially inappropriate or disruptive; or

c. experienced delusions or hallucinations within the required look-back period that impacted his/her ability to live independently in the community.

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.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:342 (January 2011), amended LR 39:1471 (June 2013).