# History & Physical (H&P) Form
## Mi Via, NM Self-Directed Medicaid Waiver Program

**(If your office or practice has its own H&P form, it may be used in place of this form. Please see delivery instructions bottom Page 2.)**

Today's Date:_____

Patient Name: _____ Date of Birth: _____

Vital Signs

Pulse: Resp: Temp: BP:

Ht: Wt:

Diagnosis(es) and ICD-9 code:

Current Medications (including OTC and supplements, if known):

Brief medical history, with specific attention to reasons for any disability (may be physical and/or cognitive/behavioral):

General/Constitutional:

Skin/Breast:

Eyes/Ears/Nose/Mouth/Throat:

**Continued, Mi Via, History & Physical/Participant Name:** _____

Cardiovascular:

Respiratory:

Gastrointestinal:

Genitourinary:

Musculoskeletal:

Neurologic/Psychiatric:

Allergic/Immunologic/Lymphatic/Endocrine:

Follow up/Comments:

**Provider (MD, DO, CNP or PAC only) Signature and Title:**

_____ Date: _____

Office Telephone: _____

**Please mail or Fax to:**

**Qualis Health – Third Party Assessor**
**PO Box 20910**
**Albuquerque, NM 87154-0910**

**Mi Via Waiver Fax Line: (800) 251-9993 (Toll Free)**

HUMAN SERVICES DEPARTMENT

# ICF/IID and DEVELOPMENTAL DISABILITIES HOME & COMMUNITY BASED SERVICES WAIVER
## LONG TERM CARE MEDICAL ASSESSMENT ABSTRACT

*The Information on this form is Confidential*

## A. General Patient Information

| 1. Assessment Type ☐ Initial ☐ Readmit ☐ Reconsider ☐ Continued Stay/Annual ☐ Change ☐ Transfer. | 2. Date of Admission or Completion of Abstract: | 3. Referral Source ☐ DDW ☐ Hosp ☐ ICF ☐ Home ☐ NF ☐ Other | 4. Medicaid Eligibility ☐ Active ☐ Pending |
|---|---|---|---|

| 5. Patient's Name *Last First MI* | 6. Medicaid Number/SSN | 7. Date of Birth | 8. Gender ☐ M ☐ F | 9. Late/Retro ☐ Yes ☐ No |
|---|---|---|---|---|
| | | | | |

## B. General Facility/Mi Via Consultant Agency/Case Management Agency

| 1. Name of Facility or Agency | 2. Mailing Address | 3. Facility Provider Number | 4. Facility NPI Number |
|---|---|---|---|
| | | | |

| 5. Facility Taxonomy # | 6. Contact Name | 7. Contact Fax # | 8. Contact Telephone # | 9. Case Manager Signature |
|---|---|---|---|---|
| | | | | |

## C. Medical Assessment - Physician, Nurse Practitioner or Physician Assistant

**1. DIAGNOSIS/PROBLEMS** - *(One per line) If resident hospitalized since last certification - enter reason:*

| *ENTER PRIMARY DD DIAGNOSIS FIRST* | ICD-10 Code |
|---|---|
| a. | |
| b. | |
| c. | |
| d. | |

**2. MEDICATION** - *List up to four most important medications, method of administration (MOA) and frequency.*

| Medication Name | MOA | Frequency |
|---|---|---|
| a. | | |
| b. | | |
| c. | | |
| d. | | |

**3. ASSESSMENT FACTORS INDICATING NEED for SPECIALIZED SERVICES.** *Place the appropriate assessment factor and score in the corresponding boxes.*

| Specialized Services | Assessment Factors | Factor Score |
|---|---|---|
| *Physical Therapy* | | |
| *Occupational Therapy* | | |
| *Speech Therapy* | | |
| *Behavior Management* | | |
| *Nursing Care* | | |

**4. SUPPORTING DOCUMENTATION.** *(Please check each document being submitted and include most current date)*

| | | |
|---|---|---|
| *Preliminary Evaluation* | | Date |
| *Comprehensive Functional Assessment* | | Date |
| *Individual Program Plan* | | Date |
| *History and Physical (H & P)* | | Date |
| *Comprehensive Initial Assessment (CIA)* | | Date |

**8. Physician's Name (Print):**

**5. ASSESSMENT FACTORS**

| A. Physical Development & Health | SCORE |
|---|---|
| 1. Health Care Supervision | |
| 2. Med Assessment | |
| 3. Med Administration | |
| **B. Nutritional Status** | **SCORE** |
| 1. Eating Skills | |
| 2. Diet Supervision | |
| **C. Sensorimotor Development** | **SCORE** |
| 1. Mobility | |
| 2. Toileting | |
| 3. Hygiene | |
| 4. Dressing | |
| **D. Affective Development** | |
| **E. Speech & Language Development** | **SCORE** |
| 1. Expressive | |
| 2. Receptive | |
| **F. Auditory Functioning** | |
| **G. Cognitive Development** | |
| **H. Social Development** | **SCORE** |
| 1. Interpersonal Skills | |
| 2. Social Participation | |
| **I. Independent Living Skills** | **SCORE** |
| 1. Home Skills | |
| 2. Community Skills | |
| **J. Adaptive Behaviors** | **SCORE** |
| 1. Harmful Behavior | |
| 2. Disruptive Behavior | |
| 3. Socially Unacceptable, Stereotypic | |
| 4. Uncooperative Behavior | |

**6. Total Assessment Factors Score _____ /22 = _____ (ICF/IID Level)**

**7. ICF/IDD Level**
- ☐ **1.0 – 2.2 = Level I/DDW LOC Eligible**
- ☐ **2.3 – 2.9 = Level II/DDW LOC Eligible**
- ☐ **3.0 – 3.2 = Level III/DDW LOC Eligible**

**a. Physician Statement** ***I have seen and evaluated this patient and recommend:***
☐ Level I/DDW LOC Eligible ☐ Level II/ DDW LOC Eligible ☐ Level III/DDW LOC Eligible

**b. Physician's Signature** | **c. Date**

**d. Mailing Address** **City** **State** **Zip Code**

## D. THIRD PARTY ASSESSOR / UTILIZATION REVIEW AGENCY SECTION ONLY

| 1. Level of Care ☐ Level I/DDW LOC Eligible ☐ Level II/DDW LOC Eligible ☐ Level III/DDW LOC Eligible | 2. Review Decision ☐ Approved ☐ Denied | 3. LOC Authorization Date Span (Start-End) |
|---|---|---|

| 4. Prior Authorization Number | 5. Reviewer's First and Last Name Initials | 6. Review Date | 7. Date of Discharge |
|---|---|---|---|
| | | | |

**8. Discharged To:** ☐ HOSP ☐ LNF ☐ HNF ☐ LAMA ☐ OTH ☐ HOME ☐ INST ☐ HHA ☐ DIED ☐ DDW

**9. Facility Discharged to:**

**DISTRIBUTION:** **Original** – TPA/UR Agency **Copy** – Facility, Fiscal Agent, ISD County Office

# Instructions for Form – Medical Assistance Division (MAD) 378
# Long Term Care Medical Assessment Abstract

**PURPOSE:** The Long Term Care Medical Assessment Abstract form (MAD 378 or "Abstract") is used in the Medicaid program to assess and issue prior authorizations (PA) for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care (LOC). Medical providers (physician, nurse practitioner or physician assistant) record a patient's medical diagnosis, medications, assessment factors for daily activities. The medical provider attests that the medical records and recommendation for an ICF/IID LOC are accurate. Supplemental medical documentation may be required to support information on the MAD 378.

The completed MAD 378 and any supplemental documentation are evaluated by a Third Party Assessor (TPA) to determine if the patient meets the State's criteria for ICF/IID LOC. When a patient meets the State's ICF/IID LOC and financial eligibility for Medicaid, they may be eligible to receive Medicaid for an ICF/IID stay or Home and Community-Based Services (HCBS) under the Developmental Disabilities Waiver (DDW) including Mi Via self-direction. The MAD 378 is also used to indicate the approved LOC date span.

**INSTRUCTIONS:**

**A – General Patient Information:** This section must contain complete patient identifying and contact information. In **box 1**, "Assessment Type", check "Initial" if this is the first ICF/IID LOC assessment. If the patient has a current ICF/IID LOC, is currently institutionalized or receiving DDW or Mi Via services, and is due for due for an annual reassessment, check "Continued Stay/Annual". A "Continued Stay/Annual" review request must be received by the TPA contractor prior to expiration of the current LOC date span. If the patient has left the ICF/IID and then returns, check "Readmit". If the physician is submitting an updated assessment because the patient's condition has changed to a different LOC, check "Change". All changes in LOC require a new MAD 378 and must be submitted within thirty (30) calendar days of the change in the patient's condition. If the LOC request was denied and the physician is submitting new information to be considered, check "Reconsider". If a patient is transferring to another ICF/IID, check "Transfer". In **box 2**, enter patient's date of admission to the ICF/IID or date abstract completed for DDW or Mi Via LOC consideration. In **box 3**, check the source of patient's referral. In **box 4**, check the current status of the patient's Medicaid eligibility. In **box 9**, check yes if your request for an LOC is late and you are requesting a retrospective LOC authorization.

**B – General Facility or Agency Information:** This section must contain case management agency or ICF/IID facility contact information. In **box 1**, enter name of the ICF/IID facility, name of the Mi Via consultant agency, or DDW case management agency facilitating the assessment. In **box 4**, enter the facility/agency 10-digit National Provider Identifier (NPI) number (no spaces or tabs). In **box 5**, enter the facility taxonomy number (no spaces or tabs). In **boxes 6, 7, and 8** enter the direct contact name, contact fax, and contact phone number for the facility, Mi Via consultant agency, or case management agency. In box 9, enter the case manager signature. For Mi Via Participants the only required information in section B is the name of the Consultant Agency in box 1 and the name of the participant's consultant as the contact name in box 6. A signature for Mi Via consultant agencies is not required in box 9.

**C – Medical Assessment:** This section must contain a patient's medical diagnosis, medications, assessment factors, indication of need for specialized services and the medical provider's attestation and recommendation for ICF/IID LOC. In **box 1**, enter the primary DD diagnosis and corresponding ICD10 code first, in line a.; the current claims reimbursement process now requires this. In **box 2**, list medications, method of administration, and frequency. In **box 3**, enter appropriate assessment factors and scores that indicate a need for the special services listed. NOTE: Factors from box 5 lend themselves to box 3; completion of box 5 prior to completing box 3 may be helpful. Information in box 3 is an assessment of LOC only, NOT an indicator of potential Medicaid services. In **box 4**, check all documents submitted with the Assessment and enter corresponding effective dates. In **box 5**, enter scores for each assessment factor based on the MAD ICF/IID admission criteria. In **box 6**, calculate and enter the Assessment Factors Score and divide by 22 to determine the Level or DDW Eligible. In **box 7**, indicate the Level or DDW LOC Eligible (e.g. if the Assessment Factors Score in box 6 is 55, then the Level or DDW LOC Eligible is 2.5 indicating Level II/DDW LOC Eligible). In **box 8**, all fields are required.

**D – This Section is completed by the TPA/UR Agency. Boxes 1-6 are required. Boxes 7-9 are required for facility discharges only.**

**ROUTING:** For DDW applicants the local case management or consultant agency coordinates with the individual, parent or guardian in order for the patient's physician to finalize the assessment process and sign/date the form. After completion, the MAD 378 is forwarded to the TPA for processing.

If the MAD 378 or supplemental medical documentation is incomplete *(required information is missing)*, the TPA will issue a request for information (RFI) to the provider. If the TPA determines that the patient does not meet ICF/IID LOC, the TPA will mail the referring parties a denial letter with the reason of denial as determined by the physician consultant. Providers who are dissatisfied with the TPA's medical necessity decision(s) may request reconsideration (see 8.350.2 NMAC). Patients who disagree with the ICF/IID LOC denial can request a Fair Hearing within (90) calendar days of the date of the notice of action (see section 8.352.2 NMAC, Recipient Hearings).

The TPA will fax copies of the completed MAD 378, inclusive of the UR decision to the appropriate Income Support Division (ISD) office, ICF/IID or Agency, and the Medicaid Fiscal Agent or MCO, as appropriate.

**FORM RETENTION:** Permanent.

# ICF/IID ADMISSION CRITERIA

**Level of Care Determination Scoring Instructions:**

1. Members of the Interdisciplinary Team need to evaluate the client of potential client in all ten assessment factors and 22 sub factors. Choose a score of 1-4 for each factor or sub factors. If factor I, Independent Living Skills, is not applicable for age-related reasons, omit it. Factor J, Adaptive Behaviors are scored 0-1.5.
2. Add the scores you've chosen for each factor or sub factor and divide by 22 for the recipient's average score. Round up to the nearest tenth if the decimal is 5 or higher, (e.g., a score 3.05 becomes 3.1). Round down to the nearest tenth if the decimal is 4 or lower (e.g. a score of 2.54 becomes 2.5).

| *ASSESSMENT FACTORS* | Score 1 | Score 2 | Score 3 | Score 4 |
|---|---|---|---|---|
| ***A. Physical Development & Health*** | | | | |
| 1. Health Care Supervision | Needs 13-24 hours of daily health care supervision by staff. | Needs 7-12 hours of daily health care supervision by staff. | Needs 0-6 hours of daily health care supervision by staff. | Infrequent health care supervision. |
| 2. Medication Assessment | Daily or weekly assessment for med effectiveness | Monthly assessment for med effectiveness. | Quarterly assessment for med effectiveness. | Infrequent med assessment. |
| 3. Medication Administration | Unable to learn self-administration | Needs hands-on assistance for med administration | Need prompts to manage med self-administration. | Usually independent in med self-administration or seldom medicated. |
| ***B. Nutritional Status*** | | | | |
| 1. Eating Skills | Unable to feed self even when assisted. | Needs hand-on assistance to accomplish eating skills. | Needs prompts to complete eating skills | Usually independent in eating skills. |
| 2. Diet Supervision | Needs staff to supervise 24-hour food and fluid intake. | Needs staff to supervise each meal closely for appropriate intake. | Needs staff to periodically monitor diet intake. | Needs infrequent staff assistance with diet. |
| ***C. Sensorimotor Development*** | | | | |
| 1. Mobility | Non-mobile and/or very limited ability to perceive environment due to sensory deficits, e.g. Blindness. | Needs hands-on assistance to use adaptive devices for mobility. | Needs prompts or minor assistance to use adaptive devices for mobility. | Usually independent in mobility. |
| 2. Toileting | Unable to perform toileting skills. | Needs hands-on assistance to perform toileting skills. | Needs prompts to perform toileting skills. | Usually independent in toileting skills. |
| 3. Hygiene | Unable to perform hygiene skills | Needs hands-on assistance to perform hygiene skills. | Needs prompts to perform hygiene skills. | Usually independent in hygiene skills. |
| 4. Dressing | Unable to perform dressing skills | Needs hand-on assistance to perform dressing skills. | Needs prompts to perform dressing skills. | Usually independent in dressing skills. |
| ***D. Affective Development*** | | | | |
| | Very limited ability to express own emotions. | Needs intervention and role-modeling to express own emotions. | Needs prompts to express own emotions. | Usually independent in expressing own emotions. |
| ***E. Speech & Language Development*** | | | | |
| 1. Expressive | Unable to communicate using a recognizable language or formal symbolic substitute. | Impaired communication in a manner not clearly understood by an unfamiliar listener. | Impaired communication in a manner sometimes understood by an unfamiliar listener. | Usually able to communicate in a manner understood by an unfamiliar listener. |
| 2. Receptive | Unable to comprehend simple communication. | Moderately impaired ability to comprehend simple communication. | Less impaired ability to comprehend communication. | Usually able to comprehend communication. |
| ***F. Auditory Functioning*** | | | | |
| | Very limited auditory function and/or limited ability to benefit from hearing devices. | Moderately impaired auditory function. Needs hands-on assistance to accept and use hearing device. | Impaired auditory function. Needs prompts to accept and use hearing device. | Normal auditory function or independent use of hearing devices. |
| ***G. Cognitive Development*** | | | | |
| | Unable to reason, remember, solve problems or transfer skills to new environment. | Needs staff assistance to perform skills in reasoning, remembering, solving problems and transferring skills. | Needs prompts to stimulate skills in reasoning, remembering, solving problems and transferring skills. | Usually independent in ability to reason, remember, solve problems and transfer skills. |
| ***H. Social Development*** | | | | |
| 1. Interpersonal Skills | Unable to establish interpersonal skills. | Needs staff assistance and role modeling to establish interpersonal skills. | Needs prompts to use interpersonal skills. | Usually independent in use of interpersonal skills. |
| 2. Social Participation | Very limited ability to participate in social and recreational events. | Needs hand-on assistance to participate in social and recreational events. | Needs prompts to participate in social and recreational events. | Usually independent participation in social and recreational events. |
| ***I. Independent Living Skills*** | | | | |
| 1. Home Skills | Unable to perform tasks such as meal preparation, laundry, bed making. | Needs hands-on assistance to perform tasks such as meal preparation, laundry, bed making | Needs prompts to perform tasks such as meal preparation, laundry, bed making. | Usually independent in performing tasks such as meal preparation, laundry, bed making |

| | | | | |
|---|---|---|---|---|
| 2. Community Skills | Unable to perform tasks such as money exchange, street survival skills. | Needs hands-on assistance to perform tasks such as money exchange, street survival skills. | Needs prompts to perform tasks such as money exchange, street survival skills. | Usually independent in performing tasks such as money exchange, street survival skills. |

**Scoring for the following Assessment Factors: Adaptive Behavior are scored with a scale of 0.0 through 1.5*

| | Score 0.0 | Score 0.5 | Score 1.0 | Score 1.5 |
|---|---|---|---|---|
| ***J. Adaptive Behavior **** | | | | |
| 1. Harmful Behavior | • High probability without intense supervision demonstrated by history, of harm to self, others or objects. This includes frequent fire setting, sexual coercion or violence, suicide attempts or refusal to follow medical therapy and or self-care to the extent that significant medical intervention or hospitalization is required.<br>• Repeated incidents requiring medical intervention (to self or others) and/or law enforcement intervention due to behavior frequency on intensity. | • Incidents of harm to self, others or objects not requiring medical or law enforcement intervention. | • Monthly incidents of minor harm to self, others, or objects. | • Rare incidents of minor harm to self, other, or objects. |
| 2. Disruptive Behavior | • Daily incidents of any behavior that substantially interferes with the individual's participation in specialized or generic support. This includes residential, day habilitation, vocational, and social support.<br>• Daily incidents of any behavior that substantially interferes with other individuals' opportunities to participate in specialized or generic support. | • Weekly or more frequent incidents of interfering with others' activities. | • Monthly incidents of interfering with others' activities. | • Rare incidents of interfering with others' activities. |
| 3. Socially Unacceptable or Stereotypic Behavior | • Daily incidents of socially offensive behavior that disrupts family, friends and/or staff capacity to interact with, instruct, or otherwise support the individual.<br>• Daily incidents of obsessive or stereotypic behavior that is difficult to interrupt or redirect to the degree that it precludes the individual's ability to participate in specialized or generic activities. | • Weekly or more frequent incidents of touching, rocking or repetitive behavior. | • Monthly incidents of touching, rocking or repetitive behavior. | • Rare incidents of touching, rocking or repetitive behavior |
| 4. Uncooperative Behavior | • Daily incidents of refusal to participate in necessary activities of daily living. This may include but is not limited to eating, bathing, dressing, and sleeping.<br>• Daily incidents of refusal to participate in planned, scheduled support activities that have been determined in accordance to the individual's preferences, abilities and interests through a person-centered IDT process.<br>• Daily refusal to participate in mandated treatment programs such as therapy for deviant sexual behavior or substance abuse. | • Weekly or more frequent incidents of non-compliance or non-participation in active treatment program. | • Monthly incidents of non-compliance or non-participation in active treatment program. | • Rare incidents of non-compliance or non-participation in active treatment program. |