

## LCD Assessor Webinar FAQs

### *Assessor Certification*

- 1. For assessors who have been around awhile and who took the training offered in 2008 on the NFCE definition, are they still required to take the Webinar on NFCE definition? The training in 2008 was one where they were issued a notebook on the NFCE definition and they attended the training personally.**

Yes. The required training is called Level of Care and can be found on the LTLTI website. NFCE definition Webinar has been removed.

- 2. Are the required modules from Boston University listed in the workbook?**

Yes, in the resource section of the workbook.

- 3. For the Des Moines University test, are there standard abbreviations we will use for the LCD?**

The Department has placed the list of approved acronyms and abbreviations on the PDA website.

- 4. Is there a cost for the Des Moines medical terminology training?**

No, there is no cost unless you want to earn the certificate. A certificate is not necessary for the assessor certification.

- 5. Is there a reporting process for the Des Moines Medical Terminology Training like the Boston University modules to ascertain completion?**

No, the assessor and supervisor will have to attest to the completion of this training.

- 6. How many times can one take the certification test until they pass?**

You can retake the exam one time. If you fail twice, you will be provided the opportunity to retest. In the interim, you will work with your supervisor on an Individual Training Plan to learn the necessary skills in the areas that you struggled with on the test. Your supervisor will again attest to your readiness before the test will be administered to you for a third time.

- 7. How do we handle employees on probationary status or employees with regular civil service status who transfer into the assessor unit if they are not successful with passing the assessor credentialing exam?**

The credentialing process for assessors as documented indicates “By December 30<sup>th</sup>, 2014. All individuals that conduct level of care assessments must be certified before they can independently completing assessment(s).”

Probationary status employees should be informed when hired that completing the training and passing the exam are part of the successful completion of the probationary period. If probationary status employees or employees who transfer with regular civil service status are unsuccessful in the exam, the supervisor needs to determine what the issues are as they relate to the employee's work performance.

All issues related to training must be addressed through the employee's work performance evaluation.

The exam is a compilation of the skills, knowledge and abilities of assessor. Credentialing/certification of assessors is a process which provides a validation of a standardized knowledge base. If the employee is unsuccessful in the certification process, the supervisor needs to focus on the employee's skills, knowledge and abilities as an assessor as evidenced by work performance, not specifically that they were unsuccessful on the exam. In other words, the work performance issue needs to be addressed. Once employees have the knowledge, skills and abilities, they will be successful in the credentialing process.

**8. How do we handle ongoing training for new LCD assessors?**

The Department will be conducting a face-to-face training in October at PDA for assessors that were unable to complete the webinar Assessor Certification trainings. We will see if a December training is needed and schedule appropriately. In addition, an interactive online training will be available in February 2015.

**9. For a new LCD assessor who started at the agency today, can she complete assessments independently?**

This will be up to the Supervisor to determine based on agency training protocols for new assessor as was done using the LOCA. After December 31, 2014, the assessor would have to be credentialed to complete an assessment independently.

**10. Our agency is concerned about the timeframe for new staff. We are not sure if they will be ready for testing by November.**

They will have until December 31<sup>st</sup> to complete all the prerequisites and to take the exam or they will not be able to conduct assessments independently.

*Level of Care Definition*

**11. What exactly is meant by room and board when people that are in PCBH, Dom Care, etc. have needs that are above room and board but are deemed NFI? Thinking of it that way, people can have care needs above room and board and be NFI.**

A level of care determination is to be made without regard to the location (locus) of an individual. If an annual recertification of level of care finds an individual to be NFCE, then that is the level of care that must be issued. This is a licensure issue and the licensing entity will have to make decisions related to NFCE status in Personal Care Homes. In Dom Care, there is a process in place by which a waiver can be requested from the Secretary of Aging for an NFCE individual to remain in a Dom Care Home.

**12. Please define "care and services above level of room and board". Do you mean assist with either/or managing medical needs, assist with ADLs?**

Room and board describes a situation where, in exchange for money, a person is provided with a place to live, as well as meals and other services.

Above the level of room and board is considered custodial care. Custodial care is nonmedical care that assists individuals with activities of daily living, preparation of special diets, and medication administration. Medical personnel are available for assessment and monitoring, but do not provide ongoing skilled services.

Many times, individuals are admitted to a nursing facility for skilled care and their condition improves and stabilizes. They require intermittent monitoring and other care and services above the level of room and board. Most public long-term care (LTC) programs, such as Medicaid, cover custodial care as long as it is provided within a nursing facility. Medicare, on the other hand, covers only medically necessary skilled care and will cover at-home custodial care only if it is provided in conjunction with skilled care.

**13. Are psychiatric conditions now considered to be the same as medical conditions such as dementia or TBI for determining level of care?**

Psychiatric conditions are medical conditions. The assessor needs to take into consideration the medical conditions, including psychiatric conditions when determining a level of care. These conditions could have an impact on functioning for ADLs and IADLs. Psychiatrists are medical physicians that specialize in psychiatric care just like a cardiologist is a medical physician that specializes in cardiology.

**14. What if a consumer clearly has Mental Health issues but no formal Diagnosis and refuses to see a psychiatrist and it clearly affects their functioning ability? According to the NFCE definition they must have a diagnosis that is currently being treated as part of the determination of NFCE.**

The individual must have physician input via a MA51/Script before someone can be determined NFCE. The assessor should document in the LCD how the Mental Health issues affect the individual's functional ability. If they have no medical diagnoses but do have functional deficits they cannot be NFCE as this does not mean the definition of NFCE.

- 15. In reference to the medication management need and NFCE determination, is it assumed that trained family/informal support fit the definition of "technical and medical personnel?"**

No, medical and technical personnel would be MDs, RNs, therapists (physical, occupational, speech, respiratory), technicians, and certified aides that provide health care.

- 16. On page 11 "other mental health diagnosis" is listed along with dementia and TBI. If the mental health diagnosis is the only reason that they cannot manage their needs such as medications, ADLs and IADLs, is that enough for NFCE? The individual has no physical impairments but cannot manage due to mental health?**

The individual must meet all aspects of the definition in order to be determined NFCE. If functional deficits are based on the medical condition [in this case a mental health diagnosis] they could be NFCE.

- 17. If a person needs only medication set up and reminders to take the medication would that person be considered to be NFCE?**

This alone may not make a person NFCE; it is the whole picture of the individual's medical conditions/diagnoses and overall ability to function.

### *Assessment Process – Timeframes*

- 18. If a referral comes in for an assessment late in the afternoon like after 3:00 or later, does the 15 day start on that day or the next day when it is assigned? Quite often PAIEB referrals come in after 4:00.**

The 15 day timeframe for a completed assessment begins on the date the referral is received. If this is a frequent occurrence with the IEB then this should be reported to OLTL.

- 19. Does the 15 day time frame pertain to all assessments regardless of locus and does the 15 day rule apply to OPTIONS?**

Yes, all LCD's must be completed within 15 days of the referral and includes the review and sign-off by the RN (if required or requested) and by the Supervisor.

- 20. When does 15 day time frame start - at the time of intake or at the time that the consumer agrees to be assessed?**

The 15 day timeframe starts the day of the referral. Any anomalies must be documented.

- 21. If we receive a nursing facility referral and then find out the person is hospitalized, how does this affect the time frame?**

If the Nursing Facility referral is received in the community then the 15 day time frame would start when the agency received the referral. Note this situation in the Journal Entries.

**22. If the 15-day timeframe starts when you receive the referral, when does it end?**

The 15-day timeframe ends when the Supervisor reviews and signs the LCD and the determination report is sent.

*MA 51 Requirements*

**23. Would you please address issues/problems commonly found with the MA51 (absence of the original MA51, medications not listed but on a separate page of orders, and issues regarding Short vs. Long Term which were extensively discussed last Summer)?**

The MA 51 must be completed in full by the physician. The AAA should not indicate Short Term or Long Term on the MA 51 (this has been verified by OLTL). The MA 51 form is DPW's form not Aging's form, please refer your questions to OLTL.

**24. Regarding PCH Re-certifications - the time frame for the AAA re-certifications is within 364 days. However, some PCH's want to use the dates of their own physician evaluations as the recertification due dates. They do not acknowledge our due dates. We have sent MA51's directly to the attending physicians in order to meet our requirements. This often results in the physicians completing two forms - the MA51 and the PCH's medical forms. Is it possible for us to use the PCH's medical document instead of the MA51 as long as it was completed within the past 364 days?**

No, a MA-51 is required by DPW for PCH re-certifications. AAAs should encourage their PCH providers to advocate with DPW for use of a single medical form.

**25. On the MA-51, do we still need to check ST/LT? Is the CAO going to question the agency why this is not marked?**

No, the short-term and long-term questions on the MA-51 should not be answered by the AAA assessor. This decision should be made by a physician or a nursing home treatment team.

**26. Will a physician script be required to complete a level of care determination for an Aging Waiver recertification assessment?**

No, the MA-51/script is not required for an Aging Waiver annual recertification.

**27. Must there be an MA/51 required prior to an NFCE determination? Without an MA51, are all LCD's NFI?**

By definition, a level of care determination of NFCE requires that a physician certify (with a recommendation on an MA-51, script, or medical certification form), that the individual is NFCE. Refer to the Mosley settlement and the OLTL bulletin # 55-12-03 for additional guidance when the 15 day time frame is near and you do not have the physician input.

**28. For the OPTIONS program, is it correct that you can be NFCE without an MA-51 or physician's script?**

No, a completed MA 51/script/physician certification is needed prior to a NFCE level of care determination. Refer to the revised assessment chapter effective July 1, 2014.

**29. Since there is no short-term or long-term on the new LCD, will the MA51s be changed as well to reflect the same?**

No, the MA-51 under section 20 A B C is for physician determination. The assessor is not responsible to complete this section of the form; this is a form to be completed by the physician

**30. Is it the service coordination agency's responsibility to notify the AAA when an annual re-cert for Aging Waiver is due?**

Yes, it is the service coordination agency's responsibility to notify the AAA when an annual recertification for an Aging Waiver is due. However; there is a report that the AAA can run in SAMS to monitor annual re-certifications.

**31. Do we need a script/ MA 51 for all current consumers in OPTIONS and CSP?**

After the OPTIONS chapter is finalized. going forward at assessment you will need to obtain a script if the consumer or care receiver is NFCE.

**32. We have an issue of scripts coming in beyond the 15 day timeframe because some physicians are not cooperating. Do we wait beyond 15 days to make a determination?**

You cannot make an NFCE determination without physician input. This input has been determined to be a physician's script or a MA-51 (as appropriate). Document all details in Journal entries as to your efforts to obtain the MA-51/script. In addition, a new question in the August revision of the LCD [#13A3] has been added. If you do not have a script when the assessment is completed a report can be generated to assist with tracking.

**33. What will we call individuals who are not applying for Waiver that do not have a MA 51 or script within 15 days (NFI or NFCE with no script)?**

They are NFCE no script.

**34. Will the MA51 be accepted if signed by a CRNP or PA?**

The MA 51 must be signed by MD or DO, this is a DPW requirement.

**35. When we go out to do a LOC determination, we usually don't get a MA 51 or script until we determine that they are NFCE. Can we do the determination and then once we determine they are NFCE LOC get the determination script or the MA51?**

The MA 51/script is not required in hand before the face to face assessment is completed. A medical(MA 51/script) is required to complete the determination of NFCE level of care. Physician input is a statutory requirement and it has been determined that a MA 51 or physician script is the vehicle.

**36. How long should we expect a period of time to pass before we get that MA51 back? How can we complete the LCD without one?**

It is recommended that the AAA place the burden of responsibility on the consumer /family as this impacts their ability to have a level of care be determined. You cannot serve the individual until you have a completed level of care determination, a completed NAT and developed a care plan. Services cannot begin until all of this is in place. If the consumer/families are aware they should assist by contacting their physician and urging them to complete the required documentation. That said, you can always complete the LCD without an MA-51/script and once received you may need to add additional information to the tool, but you cannot issue the level of care without the physician's input (the script or MA 51).

*OBRA*

**37. If the Regional Office/UMRT has stamped a PASRR...and the AAA feels the PASRR is not correct, what is the protocol?**

If the AAA feels that a PASRR ID is not correct they should contact the appropriate program office for direction on how to proceed.

*Level of Care Determination Tool*

**38. Contact information is vital as we send paperwork to the families of most consumers. We need more than just phone numbers.**

Additional contact information should be documented in the Details screen in SAMS.

**39. The instruction book (p. 197) says we do not need to offer a voter registration form to Nursing Facility residents but the LCD states that the form is required for Nursing Facility residents. Which one do we follow?**

The LCD has been corrected. The voter registration in a nursing facility is the responsibility of the nursing facility not the AAA.

**40. Question 1.E. 1 - When a consumer is long term nursing facility, and their mail goes to a POA, what address do you use?**

The assessor should use both the residential and postal/ mailing address sections of the LCD.

**41. If an individual is in a Nursing Home and we are not sure that they will be released, do we document this as their permanent residence?**

The permanent residence is the individual's home address since we do not know how long they will be in a facility. If it is a case where an individual is spending down then you know they will be in a facility permanently.

**42. In Section 1.F. on the LCD, the emergency contact address is not listed, why not?**

The purpose of the LCD is LOC determination not care planning, it was removed from the LCD and put in the NAT at the request of the supervisor's during training in summer 2013.

**43. In Section 1.F. on the LCD, should the Emergency contact work telephone number be removed?**

This will be kept on the LCD. An assessor can leave it blank if the emergency contact does not have a work telephone number.

*Use of Medical Services*

**44. Please confirm skip pattern under 2A question1. Did you say deceased was an error?**

This has been corrected in the LCD.

**45. If a chart review is being completed due to the consumer's death, do you mark "deceased individual" or "chart review"?**

Deceased Individual

**46. If someone is in a medically induced coma does that count as comatose for using the skip pattern?**

An individual is placed in a medically induced coma in response to an injury and illness. In this state an individual is still being actively treated and it would not be appropriate to conduct a level of care assessment until which time they are returned to consciousness.

**47. For clarification, does 2A#2 include observation stays?**

No, an observation stay is not considered an admission. It may be necessary for the assessor to consult with the hospital in order to determine if an individual was admitted. Refer to the definitions in the instructions for the LCD.

**48. Would you consider the psych hospitalizations in the total hospital admissions in the past year?**

Psychiatric in-patient admissions are addressed in Question 2.A.5.

*SLUMS*

**49. Do we do SLUMS on the under 60 Assessment cases also?**

Yes, the completion of the SLUMS on the LCD is mandatory if the individual is able.

**50. On p. 49, in the cognitive assessment section, we are concerned that it appears that the assessor is making a diagnosis of dementia. This is in the last question.**

The answer to Question 3.C.4 is based on the scoring presented by the SLUMS exam. The scores associated with each answer have been added to the LCD.

**51. Question 3A3-If CR answers "No", how is the worker to proceed?**

The SLUMS should be completed by the individual unless they refuse to answer the questions. Refer to the SLUMS guidance in the LCD instructions.

**52. Question 3A2-If a consumer is alert, oriented and has no cognitive issues does the worker need to continue with the SLUMS interview. It also appears insulting to complete the SLUMS on individuals who so not have cognitive impairments.**

Yes, the SLUMS should be completed by all individuals. Refer to the SLUMS guidance in the LCD instructions. Assessors and care managers need to be able to address sensitive issues with individuals. Effective communication skill is a part of the assessor credentialing process. In completing the SLUMS interview they need to be able to talk about cognitive impairment and explain the purpose of the SLUMS.

**53. Where are the items needed for 9, 10a, 10b & story in 11?**

All items needed for the SLUMS Examination are available via the SLUMS training webinar on the PDA website under resources.

**54. If a person in the Nursing Facility has already been psychologically assessed, do we still have to do the SLUMS?**

Yes.

**55. If an individual is blind, are you saying not to complete the entire exam or just the clock and geometric figures?**

Refer to the SLUMS instructions in the LCD instructions. Blindness is an indicator not to use the SLUMS.

**56. Can you please review question 6 in the SLUMS, as far as what is acceptable & what is not?**

Refer to the SLUMS instructions in the LCD instructions on page 14. The name of the animal, fish, or bird is acceptable. For example: lion, trout or robin. However; the answer animal, fish, or bird itself is not acceptable.

**57. Concerning the SLUMS, is there a way to document if a person was never able to subtract, say due to lack of education or low functioning?**

This would be addressed in Question 3.C.2., and indicate any additional information in the Notes section. This will also be reflected in the SLUMS score.

**58. Will we need to retain a copy of the completed SLUMS test with the consumer's records?**

Yes, the AAA should retain a copy of the completed SLUMS exam in the individual's case record.

**59. Is the SLUMS available in other languages?**

Yes. <http://www.elderguru.com/slums-dementia-test-available-in-various-languages/>

**60. For some consumers, family members are able to translate for the consumer. Is it recommended that an interpreter be used to administer the SLUMS if the consumer speaks another language?**

Yes, it is recommended but the individual may want to use the family. If they wish, they can, but the family needs to make sure they ask the questions as written.

**61. Background information on the SLUMS. What is the purpose?**

The SLUMS is an early screening for dementia. The purpose is to determine the assessed individual's cognitive status. It has been placed toward the beginning of the tools for the assessor to determine if the individual is capable of answering questions on their own or with assistance of others or to check medical records for additional information. When an individual has a poor outcome you will want to communicate with the individual, their family or significant other and refer them to their physician, a gerontologist or neurologist.

**62. SLUMS-3.A.2 “Do you have trouble with your memory?”the only response options are “Yes” or “No”. We would suggest an “Other-Document in Notes” because if the individual has trouble with their memory it may be that they be confused.**

Because the tool was created by St. Louis University, we cannot change/add things to it. If the individual is confused, mark “yes” that they have trouble with their memory and document details in Notes.

**63.The SLUMS is not user friendly for those who have come from outside the United States. For 3.B.11, can we use a familiar place, such as Philadelphia instead of the place listed in the question?**

No. The SLUMS has been fully tested and we need to use the exact form that has been issued. Remember this is a screening developed by a University and recommended by PDA’s Medical Director and the Alzheimer’s association.

**64.3.C.1 (SLUMS Total Score Indicator) was not being populated correctly.**

There was an error within the program which has now been corrected. If the answer is still not populating correctly, review all questions in Section 3.B. You must answer all questions for the tool to populate correctly.

**65.If an individual is very confused and the assessor is not able to follow through with the questions, does the assessment automatically skip the SLUMS?**

Do your best to ask questions to ask 3.A.2 and 3.A.3. If an individual is not able to answer, document the response to each question. The determination is made and documented in 3.A.4. If 3.A.4. is “no”, document the details and skip to bypass 3.B. and 3.C. The assessment does not automatically skip at this time.

**66.In the SLUMS, questions which have only “correct” or “incorrect” as a response, shouldn’t they also have a response of “not answered”?**

For questions which have only “correct” or “incorrect” as a response, the answer is “incorrect” if an individual does not answer. For other questions, “not answered” is a response and should be checked.

**67.Individuals are becoming annoyed/ offended/ extremely upset with the SLUMS. Some are just providing “I don’t know” answers and we are not able to capture their actual cognitive ability.**

You should be explaining the reason for the SLUMS and that some of the questions that are asked may seem strange to the individual. Before administration of the SLUMS, the individual needs to know that it is a screening as part of the level of care assessment. They should be encouraged to participate although some of the questions many seem strange.

**68. The SLUMS cannot be used with those who are visually impaired. The SPMSQ does work for those individuals because it contains only questions. We need to look at an alternative cognitive assessment for individuals who are visually impaired.**

If an individual is unable to complete all or part of the SLUMS, please indicate why in the notes. Refer to section 3 in the LCD instructions.

**69. The SLUMS is not available on the website for interpretation in Russian and Bhutanese.**

Use the interpreter for the assessment to administer the SLUMS Examination.

**70. For an individual with Parkinson's disease that cannot write, is it ok to have them point to different things in the SLUMS instead of writing?**

No, the directions must be followed as indicated. If an individual cannot complete all or part of the SLUMS, indicate the reason why in the notes.

**71. If SLUMS is unable to be completed because the individual is very ill, tired, do we need to include a blank SLUMS in their file?**

It needs to be documented in the LCD/NAT Notes section as to why it cannot be completed but it is not necessary to maintain a blank copy in the individual's file.

**72. The SLUMS instructions state that the assessor will not do the exam if the individual presents with the following: extremely ill, falling asleep, blind, unable to write, drowsy, confused, distracted, preoccupied, etc. Is there a reason the preparation question only asks if the individual is confused, distracted, drowsy, inattentive, preoccupied and doesn't address if the individual is extremely ill, falling asleep, blind or unable to write?**

Remember that you are having a conversation with the individual prior to the administration of the SLUMS screening. You should be able to identify many deficits during the introduction and communication with the individual. These questions are straight out of the St. Louis University SLUMS. We have to deliver what they have produced. If you have any pertinent details that need to be documented, document in the Notes section.

### *Diagnoses*

**73. Throughout the diagnosis sections, it refers to current. Do we consider all histories of illnesses in the LCD?**

No, unless the illness effects the current functional ability of the individual. For example, if a person had a stroke two years ago and is still paralyzed, this affects their functioning and this diagnosis would need to be documented.

**74. Why is Ascites listed under Cancer?**

Ascites is a common condition that goes along with cancer, including cancer of the colon, ovaries, uterus, pancreas and liver. It should not be a type of cancer. This has been corrected.

**75. In using diagnoses, will we be required to include notes for conditions or treatments - example, if we choose asthma as the condition, will we be required to state if there were any recent attacks? If they use oxygen, will we be required to include any notes on whether it's all day use or as necessary?**

The assessor should document any additional information in the Notes section of a question that may describe the individual's situation in more detail.

**76. If we check medication as a treatment - do we list the medications in the notes?**

No, please document medications in Section 9.D. Medication Management.

**77. High cholesterol a common diagnoses, why is in not included in the LCD?**

High cholesterol is not something that will impair functioning so that an individual would need to be admitted to a NF.

**78. If a diagnosis of blindness makes a consumer NFCE, where should that be documented?**

A diagnosis of blindness alone does not make an individual NFCE.

**79. We have done assessments on people who haven't seen a physician for 10-15 years. If they deny a diagnosis, do we document what we see? They say they don't have a pulmonary problem but are short of breath with no oxygen.**

Yes, the assessor should document any observations; however it is not the assessor's role to diagnose.

**80. Where should we document drug and alcohol conditions?**

Drug and alcohol conditions are documented in the NAT.

**81. Do we need to indicate how the diagnosis is known? (Self-reported/physician reported/family reported)?**

This information could be added to the Notes section if it is relevant.

**82. Since the category "other" has been removed where would we put any information that does not fit into any of the other categories i.e. blindness, anemia, hard of hearing etc.?**

ENT diagnoses and hearing diagnoses are no longer on the LCD and should be documented in the functional areas that they impact (ADLs mobility, IADLs). For example, if an individual

has macular degeneration and this condition affects their ability to bathe independently this would be addressed in the bathing question. Depending on the severity, this could be “limited assistance” or “total assistance” and the notes would indicate that the individual’s poor vision due to macular degeneration affects the ability to complete this task. If it is a medical condition that is supportive of the level of care determination, it should be documented in Question 13.A.4.

Anemia is addressed under Heart/Circulatory in the Diagnoses section.

**83. It would be helpful to have drop down boxes for Sepsis and Edema.**

Edema should be recorded underneath the diagnosis that is causing it. We have added sepsis under infections/Immune system section 4H.

**84. Musculoskeletal System-There is a lot of consumers with joint replacements that their functioning is being affected. It is being documented under “Other”. Will this affect the NFI/NFCE algorithm as this is listed as a primary diagnosis on the scripts that are received?**

It will be reviewed and considered to be added to the treatment section. Anything that is listed in the Notes will not be a part of the algorithm. You will need to document in 13.A.5 why you feel that the person is NFCE.

**85. In the Diagnosis section, question “Is the individual able to self-manage their condition?” what exactly are you looking for?**

Refer to the instructions definition of self-manage in section 4 of the LCD manual.

**86. Why do sections like 4.B. Heart/Circulation, bundle medical diagnosis? Is that bundling needed for the algorithm?**

The consumer needs one medical condition by itself to determine NFCE. If the condition is bundled together as one diagnosis it is still going to be picked up in the determination.

**87. In the LCD, Section 4.D.1., there is not an answer selection option for a single fracture such as a hip fracture. The answer selection only includes frequent fractures.**

The LCD will be updated and the word “frequent” will be removed from the specific answer section.

*Mental Health*

**88. For Section 7A, should they select the diagnosis if they are not officially diagnosed? Can they accept self-report and choose what they report having?**

Yes, the assessor can accept a self-report and document it as self-report. However, that will not meet the definition of NFCE without the physician input. You should verify self-report diagnoses.

*Behaviors*

**89. Some of the questions in Section 8. Behavioral, are redundant. Could they be placed in the Psychiatric or Neurological part?**

Those sections came into the tool from OLTL including staff that is involved with OBRA requirements. They will remain where they are.

*Other Medical Information*

**90. What is the difference between wandering and elopement? The definition for elopement is "one who wanders away"?**

The assessor will need to take the entire definition as documented in the instructions into consideration. Wandering could be purposeful.

**91. Question 9.A.4 Does the question apply to any type of assistance, such as physical assistance or prompting?**

If the individual is unable to evacuate the home independently the response would be "No" and the details must be documented in the notes.

**92. In regard to safely evacuating in an emergency. What if the person requires extra time due to poor mobility? Would that be considered to have difficulty with evacuating?**

"Safely" is not a term utilized in the LCD as it is very subjective. Yes, the assessor should document the details in the Notes section of the question.

*Frailty*

**93. Some individuals who are wheelchair bound are not able to walk up a flight of stairs or walk a city block. If they have five illnesses, this tool will denote that they are frail, even though they may not be. How do we handle that type of situation?**

The assessor should document the situation in the Notes section.

### *Depression/Life Satisfaction*

**94. Under section 9C for depression if the answers are yes, should there be notes?**

The assessor may add Notes under all questions. Information sufficient enough to assist with the level of care determination should be documented.

**95. For section 9C, depression, what do we do if the person is not able to answer the questions, how does it affect the algorithm?**

Document this in the Notes section. It does not affect the algorithm. The depression and frailty sections are to assist the assessor in evaluating the individual's overall condition and provide information for use when determining level of care. Historically, frailty and depression can be indicators that the individual may decline at a pace faster than an individual who is not frail or depressed.

**96. If someone is very ill or confused and is not able to answer questions on the depression screening, do we need to do it?**

No, document the details in the Notes section.

**97. For the question - how often do you feel hopeless - how is "often" defined?**

This is for the individual to answer. It is question that only the individual can describe.

**98. Do we have any flexibility in the way we ask the questions in section 9 C 5? The concern is that they will feel worse after asking all of those questions.**

No, these are tools that are nationally developed and asked in many different settings.

**99. For question 9B#1, "Are you tired?" Is this in reference to after they complete their ADLs or IADLs or is this in general?**

This question is in general.

**100. Some questions seem degrading. Example: Are you satisfied with your life? Do you often feel hopeless? The CM feels they're not counselors so where do we go if the consumer says "yes"?**

All care managers must feel comfortable talking about difficult subject matters such as abuse/neglect/ suicide/depression/frailty. These communication issues are included in the Boston University training and as a professional should be part of the job. If you have

difficulty, please seek assistance from your supervisors. Assessors should view this as an opportunity to assist by referring them to the appropriate services.

### *Height/Weight*

**101. Was it said that there will be a separate website to view a BMI calculator during the completion of the LCD?**

Yes, the assessor should refer to the website identified in the LCD instructions Section 9.E.

**102. Can we build the BMI calculation into the LCD?**

We can explore this for the future.

**103. The BMI calculator does not calculate morbid obesity. Is anything over 30 lbs. morbid obesity?**

Morbid Obesity is defined as a BMI of 40 or higher.

**104. What is the status of the BMI to self-calculate? Can we have a standardized chart as to what they Department is using to classify weight, i.e. normal, overweight, obese, morbidly obese, etc.?**

The current link we are using is from the [National Institutes of Health](#). When you go to the website and plug in the individual's information, it will give you a number. When you get the number, there will be a chart on the provided on the site to look up the individual's weight classification.

### *Pain*

**105. For the pain scale, are you planning to add in a question related to pain before and after medication?**

No, please document this information in Question 9.F.5. The NAT relates to needs and this is a needs issue not level of care.

**106. If a person has pain in more than one location would we code the higher pain and note the lower pain code?**

Yes

## Medication

### **107. Can the Medication section be moved to be before the Diagnoses?**

This has been noted and will be discussed. There is nothing that precludes you from doing this section first. The assessment does not need to be completed in order. The sections should be completed through conversation. In the assessor training we stressed that an assessment is not a question and answer period; it is a dialogue and conversation.

### **108. If the consumer is not taking their medications as prescribed, should we be listing all of their medications?**

Yes, list all the prescribed medications in Section 9.D.3, then answer question 9.D.4 as No, the individual does not take all medications as prescribed and expand documentation in the notes section to include *why* the individual is not taking the medication(s) as prescribed.

### **109. Can the medication dosage be altered so we could enter in combination dosage? (dosages with a "/") The LCD will not allow that.**

We will have to go to Harmony for that issue. In the meantime, document information on the medications in the Notes section.

## Activities of Daily Living (ADLs)

### **110. Are notes required for any answer that is not independent in ADLs and IADLs?**

Yes

### **111. Is total assist more than 50%?**

No. Total Assistance is defined as the inability of an individual to complete the ADL or IADL in full. Refer to the definitions on Page 33 of the instructions.

### **112. Can you clarify if limited assistance includes some hands-on assistance?**

Limited assistance describes an individual who may require some assistance with the ADL. Refer to definitions on Page 33. The drop down boxes indicate what assistance they need and further describes their ability or in ability to function. When a type of assistance is not listed in the drop down menu document type of assistance in the notes section.

### **113. If documented as moderate assist in a Nursing Facility chart, do we check minimum or total assist?**

The choices are independent, limited assistance or total assistance. The assessor should look at the individual's chart, talk to the Nursing Facility staff, and talk to the individual and

utilizing the information and their skills assess the individual independently utilizing the definitions in the instructions. Refer to definitions on Page 33.

**114. For bathing, does that refer to any method - bath, shower or sponge bath?**

Yes, bathing includes bath, shower or sponge bath. Please document details in the Notes section.

**115. If a Consumer needs help getting into/out of the tub with bathing but is able to bathe independently once in the tub, how do we document that?**

The assessor should document this as limited assistance and place any additional information in the Notes section. Please refer to instructions.

**116. Under walking in the ADL section, are you referring to indoor or outdoor, and is there a difference between that and walking under ambulation? (Or why is it in 2 different places in the LCD?)**

In the Mobility section we are assessing an individual's ability to move indoors and outdoors by whatever means they do this. It also looks at Stair Mobility and Weight Bearing Status. Walking in the ADL section was added to the ADL section because it is a tool to accurately measure the individual's capability of performing ADLs.

**117. If a person uses an assistive device to be independent with ADLs would that be independent or limited because of assistive device?**

The assessor would indicate that the individual is independent. Please refer to the instructions.

**118. Do we need to document in the notes if an individual needs total assistance?**

No, but you can provide additional information in the notes if appropriate.

**119. The answer selections under the ADL section 10.A.1b for bathing do not address the bathing process. The person may need different help for bathing their upper or lower extremities. If "limited assistance" is selected and they only need help for washing part of their body would you check "other" in type of assistance needed?**

The answer selection *guided maneuvering of limbs/hands on help* would be selected in this situation. Refer to the instructions for the definition of *guided maneuvering of limbs*. The LCD measures the ability of an individual, the NAT measures their needs.

## *Mobility*

**120. If a person can use an assistive device such as a trapeze to get out of bed without the assistance of another person would they be considered bedbound?**

No. An individual who is bedbound never gets out of bed.

**121. Question 11. A.5, what is Toe Touch weight bearing?**

Toe touch weight bearing is defined as the foot or toes may touch the floor (such as to maintain balance), but not support any weight. Refer to the definitions in the instructions posted on PDA's site under resources.

**122. On page 63 under mobility #6. Aphasia is listed. How does this affect mobility?**

Aphasia was added as a result of the pilot. This may affect mobility as the individual cannot tell someone they need assistance or understand what they are being told.

**123. Wheelchair mobility has been removed, if someone uses a wheelchair indoors independently how would you answer that for the mobility questions? Limited assistance with the use of a wheelchair?**

The LCD asks if the individual has the ability of movement in the interior living area and outside the living area. The method by which they are mobile is addressed in the NAT. In this example, in the LCD you would indicate "Independent" and note "uses wheelchair" in the Notes.

**124. On 11.A.4a, Stair Mobility, there is no answer for cannot use stairs. The response option of "Extensive/Total Assistance" indicates an individual can still use the stairs with assistance; however, many people cannot use stairs at all. Could there be a 4<sup>th</sup> response option of "Unable to do"?**

If there is additional information you would like to add regarding the individual's situation, add the information in the Notes.

**125. In the instructions example of the LCD of Edward Ellis, under the mobility section, a walker is considered to be limited assistance. If an individual can ambulate independently with a walker, why wouldn't they be considered independent?**

You are correct, they would be. If they are independent managing or using any ambulation devices they would be considered independent. It follows the same thought process as with the other ADLs. The LCD training materials example of Edward Ellis will be reviewed and revised as appropriate.

## *Instrumental Activities of Daily Living (IADLs)*

**126. Question 12A#5--Previously we were directed that this question is asking if the consumer has the ability to arrange transportation, now the question appears to be asking if they can drive a car or travel on public transportation. Please clarify what is to be addressed here.**

This question does address the ability to drive a car or travel on public transportation. The ability to arrange transportation is addressed in the NAT.

## *Level of Care Determination (LCD) Assessment Data*

**127. For Mosley vs. Alexander cases in which we find the consumer to be NFCE, but we have no script how should we document the questions in section 13A?**

In Question 13.A.1 indicate in the Notes section that a MA 51 was not received. Question 13.A.2 leave blank. Questions 13.A.3 indicate NFCE. Question 13.A.4 indicate the Physician Certification was not received and that the applicant is therefore NFI.

**128. Under 13 B, should there be an NFCE question with appropriate community services?**

OLTL did not want an indication on the LCD as to what services/programs may be appropriate. The outcome of an LCD is a level of care determination. It is not a care planning tool or for specific program enrollment.

**129. Question 13.C. 7 - Date Level of Care is Issued -- Is this the day the AAA issues its Determination Report to appropriate parties? Also, how do we complete this question for OBRA cases?**

Yes. For OBRA cases they will not complete Question 13.C.7. Refer to the Assessment Chapter of the Aging Policy and Procedure manual which will be effective 7/1/14.

**130. OBRA requires a narrative be sent to the appropriate program office, which used to be documented in the Decision Narrative in the LOCA. 13.A.4 in the LCD allows limited text.**

The Assessment Summary/ Decision Narrative can still be used if additional information is required for documentation.

**131. Where is the RN to write comments that she used to put in the narrative?**

The RN should write comments in the Notes section. If they have more extensive comments or need to address conflicts/issues in making a determination, they can use the Decision Narrative available as the last page in the LCD.

**132. Do RNs have to sign off on annual LCDs for Aging Waiver consumers?**

Yes

**133. Can the RN be the supervisor and sign as both or do they have to be two separate people signing after review?**

The RN and supervisor may be the same person, but must sign off on the LCD in the two different places.

**134. In the LCD, Section 13.C. has a place for the supervisor to sign and date that the assessment has been reviewed and approved, and then a date must be entered for the date the level of care is issued. If the MA 51 has not been received, can there potentially be 2 dates for the date the level of care was issued (One for the supervisor's approval and the other for the receipt of the MA 51)?**

A date cannot be put in 13.C.7 (date the level of care is being issued) until the MA 51 or script has been received. If the assessment was a referral from an IEB and the 15 day timeframe is expiring, the outcome must be documented as NFI because the MA 51 or script has not been received. An NFCE determination cannot be made without the physician's input. The Mosley settlement and OLTL bulletin provided during training outlines the procedure.

**135. The Care Manager completes the determination report when they complete an assessment. The supervisor sign on a date after it is sent and a NFCE determination cannot be made without receipt of an MA-51/ script. Should we hold off on putting a date on the determination report?**

Yes. The date the level of care is determined and the date that is entered on the Determination Report cannot be before the supervisor reviews and signs off on the LCD as the level of care is not determined until this occurs.

**136. We are having difficulty not being able to utilize the decision narrative.**

The narrative is still there. You can use it for additional notes if you would like. For example, information regarding a request for review by your Physician Consultant can be placed there. (See Question 140 below)

**137. Should we delete all narratives on recertification?**

The LCD and NAT are new. Do not use the button that says copy notes and narratives. You should never maintain ongoing narratives in an assessment tool; any documentation that is not current needs to be deleted.

**138. In Section 13.A.4. Assessment Outcome, assessors are running out of text space for their summaries.**

Refer to the examples of the case study documentation from the assessor training. This is to be a brief summary of the individual's diagnoses, treatment and implications for care. If you are running out of text space it may be that you are providing more information than is needed.

**139.If we cannot finish the assessment because we are waiting for a MA51 or script, the LCDs will not likely have the supervisor signature completed.**

For Waiver applications, the assessment must be completed within the 15 day time period. Please refer to OLTL directives for this process when a MA51 or script is not received in this time period. For PDA programs, the LCD is not considered complete until a MA51 or script is received for individuals who are determined to be NFCE. This may go past the 15 days if there is difficulty in obtaining the information. Please document in the journal notes the attempts to obtain the MA 51 or script. RN and Supervisor would sign off when it is received and reviewed.

**140.On the LCD, section 13.A.1, "What level of care did the physician recommend?" How do you answer this question for a Waiver Annual Recertification?**

You would select "Evaluation not required".

**141.Regarding the answer selection in Section 13.B.3., at an appeals hearing our agency was told that ACT 150 is no longer available for NFI consumers?**

This has been confirmed with OLTL and will be deleted as a selection in this question.

*Place of Service Preference*

**142.Why are OPTIONS and Caregiver Support Program NFCE not a choice?**

Because all Aging consumers that are determined NFCE and seeking community based services must apply for the Aging Waiver (Mandatory Enrollment). These choices are only for a NFI Level of Care determination.

*Algorithm*

**143. If the algorithm determines a consumer to be NFCE and the assessor determines them NFI, is an RN review needed?**

No, this is optional, but a discussion with the RN and or the Supervisor might be indicated..

**144. When will the algorithm for level of care in the LCD be working?**

We will be turning this feature on in the future after we study the LCD results and test the algorithm. We are working on ensuring the instructions are followed for completion of the LCD that makes the algorithm work correctly.

### *General Questions*

**145. If we assess in the nursing facility for MA payment and they also want to go home in a few months with Aging Waiver do we only need one assessment since NFCE is NFCE? What about service delivery there would not be an outcome for the Aging Waiver assessment?**

Yes. There is no need to do a service delivery for the Aging Waiver as you do not need to complete an additional LCD.

**146. Our AAA has a rule that if someone is out of home for 30 days - LOCA is required.**

A new LCD only needs to be completed if an individual experiences a change in level of care or a change in condition.

**147. Will there be a new determination report issued without long vs. short term?**

Yes, there will be a Level of Care Determination Form issued which replaces the OPTIONS Determination Report. Refer to the Assessment Chapter effective July 1, 2014.

**148. We only send OPTIONS Determination Reports to consumers, etc. when a Preadmission LOCA is completed. We do not complete them for OPTIONS LOCA consumers. Will this change after July 1st?**

No, the Level of Care Determination Form is only for individuals seeking Medical assistance benefits and outlines the appeal process. Appeals for other individuals are addressed in the Hearing and Appeals Chapter.

**149. Will a LCD have to be completed for every existing participant or will the NAT populate from the current CMI or LOCA?**

After July 1, 2014, a LCD should be completed for an existing participant when an individual is due for recertification or experiences a change in their condition. The CMI will only populate the NAT if the questions are exactly the same. The only time a NAT should be used to

populate an LCD is, if at reassessment there is an indication that the level of care has changed or there is a significant change in condition that would require a new LCD.

**150. Can you please share the field operations phone number?**

Yes, the Headquarters' Field Operations phone number is (717) 783-7377.

**151. In our experience, some Consumers appear to be untruthful during assessments regarding their functioning to present with greater need to possibly try to get increased PAS hours. Do you have any suggestions on how to motivate consumers/supports to be truthful in responses?**

The assessor may want to have a conversation with the individual that their medical conditions and/or diagnoses do not support what is being described as their functional ability. They should also contact the Primary Care Physician and /or request additional medical records.

**152. Are notes only required if the drop down box does not answer the question?**

No. The Notes section should be used any time the assessor wants to provide additional information.

**153. Our agency would like some clarification on Executive Functioning for our assessors.**

The Department and P4A are exploring a webinar the purpose of the SLUMs and Executive Functioning.

**154. Is assessment information available for editing after mid-July? What if our agency is still waiting for a script that we are having difficulty obtaining?**

The LOCA will be available for editing in SAMS/OMNIA.

**155. The assessments are difficult to navigate. We would hope that each section under medical that there would be a first response of "none".**

Enter the response as "none", then push the enter key and it will skip to the next section. Do not use the arrow key.

**156. LCD/NAT being completed at the same time during initial visit. Participants are getting upset with being asked the medical questions twice; LCD asks the medical conditions, NAT asks for the symptoms. Many do not know the diagnoses but do know the signs and symptoms.**

It is not recommended that these tools be completed at the same time as they are completed for two very different and distinct purposes. For agencies where assessment and care management functions are not separated, it is important to explain to the individual that the purpose of your visit is two-fold: determining a level of care and assessing needs. Neither

assessment tool should be completed as just a question and answer session going through the tool from start to finish. Information will be gathered as you engage in conversation with the consumer which may require making notes on certain information that is learned and adding it into the tool later. If an LCD has been created at the main OMNIA site, export to the local, complete the LCD and while in the field create the NAT from the LCD using the Reassess feature.

**157. How do we know if a consumer in a nursing home is still NFCE when we go out to do an assessment to discharge a consumer? You say it's not necessary to do another LCD.**

There is no need to do an assessment to discharge a consumer from a nursing home unless it is determined that the individual's level of care has changed to NFI. This should be learned from the referral information you receive. In addition, it would not be appropriate to assess an individual for in-home services before they return home as their home environment is an essential part of the information needed in determining needs and developing a care plan to meet these needs.

**158. Do all NFI OPTIONS reassessments need to have a LCD completed along with a NAT?**

No.

**159. Is the LCD good for 1 year as the LOCA was or is there another timeframe?**

A LCD must be completed yearly for the Waiver. For other PDA programs, it is completed initially and then only when the medical condition changes. It is completed only initially for nursing facility admission unless the condition improves and they may no longer be NFCE. There is no need to complete another LCD based on locus of care.

**160. In cases where a nursing facility requests a second LCD, if there is not a change in the individual's condition, another LCD does not need to be completed?**

Yes. However, if the AAA is not able to determine if a change in condition occurred based on the referral another LCD can be completed.

**161. If someone was once determined to be NFI and is now found NFCE, do we need a script?**

Yes

**162. What do we do with an individual in a PCH who is NFCE?**

The level of care is what it is, regardless of where they reside. The individual stays in the PCH, only the CAO can cut off their supplement. The assessor is responsible to conduct the assessment not determine placement.

## SAMS

**163. Do we select short term or long term on the service delivery of a NFCE case on the outcome in SAMS?**

Short Term or Long Term for the Service Delivery has been deactivated in SAMS.

**164. Regarding the Activities & Referrals on page 123. Do we understand correctly, the date of referral is an activity, a call and a journal note for every intake that comes into the office?**

There are no longer mandated A&Rs. We have recommended that, for management of workload using dashboards, that identified A&R's be used.

**165. Also is there to be a journal note for every activity and referral?**

Activity & Referrals are no longer mandated, relevant information should be in a journal note which cannot be edited.

**166. With the LCD we are using the non-care managed care enrollment. Is the service delivery then going to remain as part of the process in SAMS?**

Yes, the agency cannot be reimbursed for an LCD unless there is a service delivery.

**167. This question is on the last section. Will PCH recertification LCD be listed under Non-care management now or will they continue to be listed under the PCH enrollment?**

The LCD should be delivered under the PCH enrollment.

**168. By removing guardian and POA we may not know where to send the determination or where to get signatures for all required forms that need signed.**

This information should be entered in SAMS on the Details screen under Contacts. There is a drop down box to be used for type of POA or guardian. The address and phone number information can be added under location and there is also a comment box.

**169. We do not import or export, is it still required as per assessor checklist?**

You need to be able to function in SAMS to electronically save and deliver an assessment on an as needed basis.

*OLTL Bulletin 55-12-03*

**\*\*\*All questions pertaining to this Bulletin or the Aging Waiver must be directed to the Office of Long Term Living.**