# H-Assessments/Re-assessments

## H-100 Overview

The Resident Assessment Instrument (RAI)-Minimum Data Set - Home Care (MDS-HC) is a comprehensive and standardized assessment tool used to evaluate the needs, strengths, and preferences of the individual for all initial, annual, status change, and follow-up assessments.

The MDS-HC assessment/re-assessment is completed with the individual in order to:

- Verify that the individual meets level of care criteria.
- Identify the individual's preferences.
- Identify paid and unpaid supports (including family and community supports).
- Determine the Resource Utilization Groups (RUGs) score, Activities of Daily Living (ADL) Index score, and corresponding Service Hour Allocation of Resources (SHARe) budget allocation.
- Establish baseline information in regards to the individual's functional abilities.
- Identify acute and chronic health conditions that may impact the individual's self-performance.
- Identify health and welfare concerns.
- Determine if the individual has the capacity to make decisions for himself/herself.

## H-110 Completion of the Assessments/Re-assessments

The MDS-HC assessment/re-assessment, including the Degree of Difficulty Questions (DDQs) must be completed at a face-to-face visit with the individual by a certified assessor. For details on instructions for completing the MDS-HC assessment or re-assessment, refer to the MDS-HC Manual and the Level of Care Manual.

In order to obtain an accurate assessment, the SC will need to evaluate the participant's capacity to accurately self-report information. To make this determination, the SC will:

- Use professional judgment and observation to determine the participant's cognitive, mental/behavior and communication status.

- Use MDS-HC sections regarding cognition, communication barriers and behavioral challenges, to determine if an individual has the capacity to make decisions for himself/herself and provide accurate information to complete the assessment.
    - SC shall use a procedural memory problem code of 1, daily decision making code of 3 or 4, making self-understood or understanding others code of 3 or 4, delusions or hallucinations code of 1 to indicate the participant may not have the capacity to be considered a reliable self-informant.

- Review secondary documents, such as medical records, home health plan of care, nursing notes, therapy notes, when available and applicable.

- If it is determined that an individual does not have the capacity to provide accurate information, a responsible representative or secondary informant may be needed to accompany, assist, and represent the individual in the MDS-HC assessment process. The responsible representative/secondary informant can assist in gathering all necessary information for this process.

- If the participant does not have a RR, a secondary informant may be another family member, DSW, friend, neighbor, home health representative, social worker, mental health counselor, or any individual that may be familiar with the participant.

- Once a secondary informant is identified, the SC will contact and invite the individual to the assessment meeting. (The MDS-HC assessment meeting may need to be rescheduled for an alternate date and time.)

- If the SC is unable to identify a RR or secondary informant, the SC will contact OAAS R.O. for guidance.

**Note: If an individual designates someone as his/her responsible representative or secondary informant he/she will still have the right and the responsibility to actively take part in his/her assessment.**

Participants who are competent majors, defined as individuals eighteen years of age or older, unless a court has declared the individual to be incompetent, have the right to control who participates in the assessment process and have the right to refuse participation by secondary informants.

RO will:

- Review the case to ensure no secondary informant is available. If identified, refer to SC to complete the assessment with the newly identified informant.

- If no secondary informant is available, refer case to SRP for review and final decision.

**NOTE: Participants may request another MDS-HC Assessment/ Re-assessment at any time.**

**Note: MDS-HC Assessments or Re-assessments should not be completed in a hospital or long term acute care facility (LTAC). Assessments should be completed at minimum 7 days after the participant discharges to home.**

## H-120 Initial Assessments

The process for initial assessments is the same for individuals residing in the community and those individuals residing in the nursing facility (NF).

SC must:

- Complete the MDS-HC assessment face-to-face with the individual and/or members of his/her support network within three (3) working days of starting the MDS-HC assessment.

- Input the MDS-HC assessment into the database within five (5) working days from the completion date of the assessment.

- Obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation.

- Determine if the individual meets nursing facility level of care (Refer to Level of Care Manual).

**NOTE: For ADHC Waiver and needing/requesting Long Term-Personal Care**

**Services (LT-PCS), the individual must meet NF LOC and LT-PCS program requirements, which is needing at least limited assistance with at least one (1) activity of daily living (ADL).**

**If individual meets NF LOC but does NOT meet LT-PCS program requirements, which is needing at least limited assistance with at least one (1) ADL, he/she can receive ADHC Waiver but not LT-PCS.**

- Determine if the individual is a good candidate to transition from the NF (if applicable).

- Proceed with POC development, once all assessment information is gathered and it appears that the individual meets NF LOC and/or programmatic criteria (Refer to Plan of Care Development section).

If the individual does **NOT meet NF LOC**, the SC will complete a narrative (including sufficient documentation to substantiate that the individual does not meet LOC) and submit to SC supervisor for review.

SC supervisor will review and approve the denial to be submitted to RO for closure.

SC/SC supervisor will complete CMIS closure form and email denial documentation to RO for review.

RO will:

- Review and verify that the individual does not meet LOC.

- Send out a denial notice to the individual with appeal rights and a copy to the SCA.

  If the individual appeals the decision, refer to the Appeals procedures. After the 30 days for appeal rights have passed AND the individual did NOT appeal, RO will complete a 142 (Refer to 142 instructions) indicating “Not Approved” and email a copy to Medicaid, DMC and the SCA.

  SC will close the case in CMIS.

If the individual does **NOT appear to be a good candidate to transition from the NF**, the SC will complete a narrative (including sufficient documentation to substantiate findings) and email all documentation to RO.

SC supervisor will review and approve the case to be submitted to RO for closure.

SC/SC supervisor will email documentation to RO for review.

RO will:

- Review and verify that the individual appears to not be a good candidate to transition from the NF.

- Email all relevant documentation for review to the designated Service Review Panel (SRP) members.

  If SRP determines that the individual is not a good candidate to transition from the NF (due to health and welfare, waiver services not appropriate, etc.), RO will send a denial letter with appeal rights to the individual and a copy to the SCA.

  If the individual appeals the decision, refer to the Appeals procedures. After the 30 days for appeal rights have passed AND the individual did NOT appeal, RO will complete a 142 (Refer to 142 instructions) indicating "Not Approved" and email a copy to Medicaid, DMC and the SCA.

SC will close the case in CMIS.

## H-130 Follow-Up Re-assessments

For NF Transitions Only:

If the participant is certified for the Community Choices Waiver (CCW) when he/she moves out of the NF, the SC must complete a Follow-Up MDS-HC Re-assessment six (6) months from the date the participant moves out of the NF.

If the participant is NOT certified for the Community Choices Waiver (CCW) until after he/she moves out of the NF, the SC must complete a Follow-Up MDS-HC Re-assessment six (6) months from the date the participant is certified for CCW services.

**NOTE: If the six (6) month date falls on a weekend or holiday, re-assessment should be completed on the following business day.**

This Follow-Up re-assessment does not need to be completed if a status change re-assessment was conducted within 4 to 6 months from the date of the initial MDS-HC assessment.

If the Follow-Up re-assessment does **NOT** indicate that the participant meets NF LOC, the SC should proceed with discharge procedures.

SC must:

- Complete the Follow-Up MDS-HC re-assessment face-to-face with the participant and/or members of his/her support network six (6) months from the date the participant moves out of the NF.

**NOTE: Provider(s) are not required to be at the re-assessment meeting, UNLESS the participant requests the provider(s) to be present at the meeting.**

- Input the MDS-HC re-assessment into the database within five (5) working days of the date of the face-to-face follow-up re-assessment meeting.

- Obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation to see if different from previous MDS-HC assessment.

- Determine if the individual continues to meet NF LOC (Refer to Level of Care Manual).

- If the individual does NOT continue to meet nursing facility level of care, the SC will complete a narrative (including sufficient documentation to substantiate that the individual does not meet LOC) and complete CMIS Closure form and email to RO.

RO will:

- Review and verify that the individual does not continue to meet LOC.

- Send out a discharge notice to the individual with appeal rights (including proposed termination in services notice) and a copy to the SCA.

If the individual appeals the decision, refer to the Appeals procedures.

After the 30 days for appeal rights have passed AND the individual did NOT appeal.

SC will:

- Complete an e148-W for closure (Refer to e148-W instructions).
- Complete Case Management Information System (CMIS) Closure form and email to RO.

RO will:

- Approve the e148-W closure.
- Email a copy of CMIS Closure form and Medicaid Decision Notice (Denial Letter) to the DMC.

**NOTE: DMC receives a copy of the e148-W electronically through the database.**

SC will:

- Close the case in CMIS.
- Notify the provider(s) by speaking to a representative, by email and/or via fax on the same date that e148-W denial is approved by RO.

If it appears that the individual continues to meet LOC, AND RUGs score, ADL Index Score, triggered CAPs and/or concerns are same as previous MDS-HC assessment, the SC will review the current POC with the participant.

If it appears that the individual continues to meet LOC, AND RUGs score, ADL Index Score, triggered CAPs and/or concerns are different from the previous MDS-HC assessment, the SC will proceed with POC Revision to address the change(s) (Refer to POC Revision section).

## H-140 Change in Status Re-assessments

SCs are responsible for completing a Change in Status Re-assessment when there is a significant status change (improvement or decline) in the participant's condition.

If the SC determines that the participant has a Significant Status Change (SSC), the SC must:

- Complete the Change in Status re-assessment face-to-face with the

participant and/or members of his/her support network on the fourteenth (14th) calendar day from the date of the notice of a change in the participant's condition.

**NOTE: If the fourteenth (14th) day falls on a weekend or holiday, re-assessment should be completed on the following business day.**

**Provider(s) are not required to be at the re-assessment meeting, UNLESS the participant requests the provider(s) to be present at the meeting.**

**NOTE: If the change in status involves a hospital or LTAC stay, the assessment will need to be completed 7 to 14 days from the date discharged to home.**

- Input the MDS-HC re-assessment into the database within five (5) business days from the date of completing the Change in Status re-assessment.
- Obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation to see if different from previous MDS-HC assessment/re-assessment.
- Determine if the individual continues to meet NF LOC (Refer to Level of Care Manual).
- If the individual does NOT continue to meet NF LOC, the SC will complete a narrative (including sufficient documentation to substantiate that the individual does not meet LOC) and complete CMIS Closure form and send to RO.

RO will:

- Review and verify that the individual does not continue to meet LOC.
- Send out a denial notice to the individual with appeal rights (including proposed termination in services notice) and a copy to the SCA.

If the individual appeals the decision, refer to the Appeals Procedures.

After the 30 days for appeal rights have passed AND the individual did NOT appeal.

SC will:

- Complete an e148-W (Refer to e148-W Instructions).
- Complete CMIS Closure form (including sufficient documentation to substantiate that LOC was not met).
- Send to RO.

RO will:

- Approve the e148-W closure.
- Email a copy of the e148-W, CMIS Closure form, and Medicaid Decision Notice (Denial Letter) to the DMC.

SC will:

- Close the case in CMIS.
- Notify the provider(s) by speaking to a representative and by email on the same date that e148-W is received from RO.

If it appears that the individual continues to meet LOC, AND RUGs score, ADL Index Score, triggered CAPs and/or concerns are same as previous MDS-HC assessment, the SC will review the current Plan of Care with the participant.

If it appears that the individual continues to meet LOC, AND RUGs score, ADL Index Score, triggered CAPs and/or concerns are different from the previous MDS-HC assessment, the SC will proceed with POC Revision to address the change(s). (Refer to POC Revision Section).

**NOTE: If the Status Change MDS-HC re-assessment does NOT indicate a change in the participant's status, the SC should NOT complete a POC Revision.**

## H-150 Annual Re-assessments

SCs are responsible for completing an Annual MDS-HC re-assessment on **all** participants (even if the participant is still residing in the NF).

**NOTE: If the annual MDS-HC re-assessment does NOT indicate that the participant meets NF LOC, the SC should proceed with discharge procedures.**

SC must:

- Complete the Annual MDS-HC re-assessment face-to-face with the participant and/or members of his/her support network no earlier than 90 calendar days from the POC Expiration Date.

**NOTE: POC Expiration Date is the day after the POC End Date. (e.g. a POC end date of 9/28/13 would have an expiration date of 9/29/13).**

**Provider(s) are not required to be at the re-assessment meeting, UNLESS the participant requests the provider(s) to be present at the meeting.**

- Input the MDS-HC re-assessment into the database within five (5) working days from the date of completion of the annual re-assessment.

- Obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation to see if different from previous MDS-HC assessment.

- Determine if the individual continues to meet nursing facility level of care (Refer to Level of Care Manual).

  If the individual does NOT continue to meet nursing facility level of care, the SC will complete a narrative (including sufficient documentation to substantiate that the individual does not meet LOC) and complete CMIS Closure form and send to RO.

  RO will:

  - Review and verify that the individual does not continue to meet LOC.

  - Send out a denial notice to the individual with appeal rights (including proposed termination in services notice) and a copy to the SCA.

If the individual appeals the decision, refer to the Appeals Procedures.

After the 30 days for appeal rights have passed AND the individual did NOT appeal.

SC will:

- Complete an e148-W (Refer to e148-W Instructions).
- Complete CMIS Closure form (including sufficient documentation to substantiate that LOC was not met).
- Send to RO

RO will:

- Approve the e148-W closure.
- Email a copy of the e148-W, CMIS Closure form, and Medicaid Decision Notice (Denial Letter) to the DMC.

SC will:

- Close the case in CMIS.
- Notify the provider(s) by speaking to a representative and by email on the same date that e148-W is received from RO.

If it appears that the individual continues to meet LOC, the SC will proceed with developing a new POC with the participant (Refer to Plan of Care Development Section).