Medically Fragile Group Criteria Certification Form Instructions

Effective 04/18/2024

Purpose

The purpose of the Medically Fragile Group Criteria Certification Form is to document the medical fragility of an applicant or member requesting a medically fragile group exception within the STAR+PLUS Home and Community Based Services (HCBS) program. This form also serves as an attestation form, requiring the managed care organization (MCO) medical director to certify that an applicant or member meets the medically fragile group criteria.

In this form, "MCO" refers to STAR+PLUS MCOs and Medicare-Medicaid Plans.

Procedure

When to Prepare

The MCO service coordinator or medical director completes the form when the MCO determines an applicant or member is medically fragile and his or her health and safety cannot be protected within the assigned Resource Utilization Group (RUG) cost limit.

Form Retention

Each MCO must keep the Medically Fragile Group Criteria Certification Form according to the retention requirements found in all Medicaid managed care contracts and federal regulations. The MCO must keep all originals/electronic copies of this form in the member's folder/electronic record for five years after services are terminated.

Detailed Instructions

Name – Enter the name of the applicant or member.

DOB (Date of Birth) – Enter the date of birth of the applicant or member.

Medicaid Number – Enter the Medicaid number of the applicant or member.

Initial Submission or Annual Reassessment (check one of the following):

- Check "Initial Submission" if the applicant or member has not been authorized for the medically fragile group previously or if there has been a gap in authorization for the medically fragile group or the general revenue group of two years or greater.
- Check "Annual Reassessment" if the member has been authorized for the medically fragile group or general revenue group within the last two years.

RUG Value* (check one of the following):

- Check "SE1" if the applicant or member has an assigned Resource Utilization Group (RUG) Value of SE1.
- Check "SE2" if the applicant or member has an assigned RUG Value of SE2.
- Check "SE3" if the applicant or member has an assigned RUG Value of SE3.

*Leave blank if the applicant or member has an assigned RUG Value that is not SE1, SE2 or SE3. Members or applicants with RUG levels that are not SE1, SE2, or SE3 do not meet submission requirements for the medically fragile group. If the MCO believes an applicant or member with a RUG level other than SE1, SE2 or SE3 may qualify for the medically fragile group, the MCO staff must email the High Needs Utilization Review prior to submission to discuss the rationale for submission.

Name of MCO Staff Completing Form – Print the name and job title of the MCO staff completing the form.

Primary Medical Diagnosis (assigned by physician) – Enter the primary medical diagnosis the applicant's or member's physician has identified. Do not enter what the applicant, member or authorized representative feels is the member's primary diagnosis. Medical records should be utilized to complete this item.

Has the member had a change in medical condition from the previous ISP year? (check one of the following):

- If the member has had a change in medical condition from the previous ISP year that has required an increase in necessary services, check "yes."
- If there has been no change in medical condition from the previous ISP year, check "no."

If "yes" is checked above to indicate the member had a change in medical condition from the previous ISP year, briefly explain what changed.

Medically Fragile Group Clinical Criteria – Check any applicable criteria and fill out the frequency of occurrence in a 24-hour period unless otherwise noted. Criteria must be supported by medical documentation, such as nursing notes, ventilator, seizure, or suction logs, and medication administration records. Documents generated by the MCO service coordinator will not be used as documentation for the medically fragile group criteria listed below.

Tracheostomy – Check this box if the applicant or member has a tracheostomy.

Frequency of Suction: Tracheal – Indicate the average number of times an applicant or member is suctioned via tracheostomy within a 24-hour period.

Frequency of Suction: Naso-pharyngeal – Indicate the average number of times an applicant or member is suctioned via a naso-pharyngeal route within a 24-hour period. Naso-pharyngeal suction can be completed whether or not an applicant or member has a tracheostomy. The applicant or member must have orders in plan of care for this naso-pharyngeal suction intervention.

Ventilator (check one of the following):

- Check "A/C" if an applicant or member is receiving ventilation utilizing assist/control (A/C) settings.
- Check "SIMV" if an applicant or member is receiving ventilation utilizing synchronized intermittent mandatory ventilation settings (SIMV).

Utilization of Ventilation (complete one of the following):

- Check "Continuous" if the applicant or member is receiving ventilation utilizing A/C or SIMV settings continuously in a 24-hour period.
- If the applicant or member is not receiving ventilation continuously in a 24-hour period, indicate the number of hours in a 24-hour period the applicant or member is receiving A/C or SIMV ventilation.

CPAP/BIPAP/AVAPS: Continuous (complete one of the following):

- Check "Continuous" if the applicant or member has a tracheostomy and is receiving continuous positive airway pressure therapy (CPAP) or bilevel positive airway pressure (BIPAP) or AVAPS mode continuously in a 24-hour period.
- If the applicant or member has a tracheostomy and is not receiving CPAP, BIPAP or AVAPS mode continuously in a 24-hour period, indicate the number of hours in a 24-hour period the applicant or member is receiving CPAP, BIPAP or AVAPS.

Respiratory Treatments: Nebulizer: Scheduled – Indicate the number of scheduled nebulizer treatments the applicant or member receives in a 24-hour period. If an applicant or member receives more than one scheduled type of nebulizer treatment, all should be recorded here.

Respiratory Treatments: Nebulizer: PRN in a 14-day period - Indicate the total number of pro re nata (PRN) or "as needed" nebulizer treatments the

applicant or member received in the *14-days that correspond with the dates of the nursing notes submitted.*

Respiratory Treatments: O2 (complete one of the following):

- Check the box marked "Continuous" if the applicant or member is receiving supplemental oxygen continuously in a 24-hour period.
- If the applicant or member is not receiving continuous supplemental oxygen, indicate the number of hours the applicant or member is receiving supplemental oxygen in a 24-hour period.
- If the applicant or member is only receiving PRN or "as needed" supplemental oxygen, indicate the number of times oxygen was *required in a 14-day period. This 14-day period must correspond with the dates of the nursing notes submitted.*

Respiratory Treatments: IPV – Indicate the number of times the applicant or member receives intrapulmonary percussive ventilation (IPV) in a 24-hour period.

Respiratory Treatments: IPPB – Indicate the number of times the applicant or member receives intermittent positive pressure breathing therapy in a 24-hour period.

Respiratory Treatments: Cough Assist – Indicate the number of times the applicant or member uses a cough assist or other similar machine in a 24-hour period.

Respiratory treatments: CPT: Manual – Indicate the number of times the applicant or member receives manual chest percussion therapy in a 24-hour period.

Respiratory treatments: CPT: Vest – Indicate how many times the individual receives vest chest percussion therapy in a 24-hour period.

Medication Administration: Enteral Tube – Check "Enteral Tuble" if the applicant or member received any amount of long term or routine medications via enteral tube.

Medication Administration: IV Therapy – Check "IV Therapy" if the applicant or member received long term or routine medications intravenously in the home setting (do not include medications administered via Port or a peripherally inserted central catheter (PICC) here).

Medication Administration: Injections – Check "Injections" if the applicant or member received any type of injection (intramuscular, subcutaneous) in the home setting.

Medication Administration: Port or PICC – Check "Port/PICC" if the applicant or member received long term/routine medication via a central venous catheter or PICC in the home setting. Do not check this box if the port or PICC was accessed only for normal saline or heparin maintenance flushes.

Nutrition: Enteral Tube Feed (complete one of the following):

- Check "Continuous" if the applicant or member receives nutrition via enteral tube continuously over a 24-hour period.
- If the applicant or member does not receive continuous enteral tube feeds, use the "Frequency/#of hours if Intermittent" section to indicate the frequency of feeds within a 24-hour period. This section can be used to indicate if the feeds are provided by bolus, pump or both.

Nutrition: TPN (complete one of the following):

- Check "Continuous" if the applicant or member receives Total Parenteral Nutrition (TPN) continuously over a 24-hour period.
- If the applicant or member does not receive TPN continuously, indicate the frequency/# of hours the TPN is administered in a 24-hour period. If the TPN is not administered 7 days a week, indicate the number of days a week it is administered.

Seizures: Frequency – Indicate the number of seizures the applicant or member averages in a 24-hour period. Medical records or seizure logs should be used to determine this average.

Seizures: # of Rescue Interventions in a 14-day period - Indicate the number of rescue interventions that occurred in the 14-days that correspond with the nursing notes submitted. Rescue interventions could include bag-valve-mask ventilation, rescue breaths, supplemental oxygen, or rescue medications such as Diastat.

Pressure Sores/Injuries: Stage I – Indicate the number of pressure sores or injuries at Stage I.

Pressure Sores/Injuries: Stage II – Indicate the number of pressure sores or injuries at Stage II.

Pressure Sores/Injuries: Stage III – Indicate the number of pressure sores or injuries at Stage III.

Pressure Sores/Injuries: Stage IV – Indicate the number of pressure sores or injuries at Stage IV.

Pressure Sores/Injuries: Unstageable – Indicate the number of unstageable sores or injuries.

Ostomy/Catheter – Check the box(es) (Foley, I/O Catheterization, Nephrostomy, Suprapublic Catheter, Colostomy, Ileostomy) that correspond to any ostomy or catheter type the individual has. Do not check intermittent (I/O) catheterization if the applicant or member has a physician's order but intermittent catheterization is not occurring.

Dialysis (check one of the following):

- Check hemodialysis if occurring in the home or in an outpatient setting.
- Check peritoneal dialysis regardless of who is performing it.

Indicate the weekly frequency of either dialysis.

Functional Status – Indicate the applicant's or member's overall ability to perform activities of daily living using information obtained from the Medical Necessity/Level of Care (MN/LOC), Section G "Functional Status." (Check one of the following.)

- Check "Total Dependence" if MN/LOC Section G0110 was coded "Total Dependence" for at least half or more of the activities.
- Check "Extensive Assistance" if MN/LOC Section G0110 was coded "Total Assistance" for at least half or more of the activities. If coding was equally split between two, choose the most dependent.

Other Pertinent Information – Provide any relevant clinical information not captured in other sections of this form. If the applicant or member is not SE RUG designated, provide information as to why MCO believes they meet the medically fragile group criteria. For example, document any information the MCO may have on hospital admissions or emergency room visits here. Do not recap information previously recorded.

MCO Medical Director Certification – The MCO medical director checks this box to attest the form and submitted documentation has been reviewed and the applicant or member meets the medically fragile group criteria marked on the form.

Signature – MCO Medical Director – The MCO medical director who has completed or reviewed the form, documentation and has checked the certification box signs the form.

Date – Enter the date the MCO medical director signed the form.

Phone Number – Enter the phone number of the MCO medical director who signed the form.

Printed Name of MCO Medical Director – Print the name of the MCO medical director who signed the form.

Specialty of Signing MCO Medical Director – Enter the medical specialty of the MCO medical director who signed the form.