Medically Fragile Group Criteria Certification Form

Name Click here to enter name.
DOB Click here to enter DOB.
Medicaid Number Click here to enter Medicaid Number.

Initial Submission ☐ **Annual Reassessment** ☐

RUG Value: SE1 ☐ SE2 ☐ or SE3 ☐

Name of MCO Staff Completing Form: Click here to enter name

Primary Medical Diagnosis (assigned by physician): Click here to enter diagnosis.

Has the member had a change in medical condition from the previous ISP year? Yes ☐ No ☐ If yes, explain: Click here to enter text.

Medically Fragile Group Clinical Criteria: Check any applicable clinical criteria and fill out the frequency of occurrence in a **24-hour period unless otherwise noted**.

Tracheostomy ☐ **Frequency of Suction:** Tracheal Click here to enter frequency. Naso-pharyngeal Click here to enter frequency.

Ventilator: A/C ☐ SIMV ☐

Utilization of Ventilation: Continuous ☐ If not continuous, # of hours Click here to enter hours.

CPAP/BIPAP/AVAPS: Continuous ☐ If not continuous, # of hours Click here to enter hours.

Respiratory Treatments: Nebulizer: Scheduled Click here to enter # of treatments. PRN in a 14-day period Click here to enter # of treatments.

O2: Continuous ☐ If not continuous, # of hours Click here to enter # of hours. PRN in a 14-day period Click here to enter # of times O2 required.

IPV Click here to enter #.

IPPB Click here to enter #.

Cough Assist Click here to enter #.

CPT: Manual Click here to enter #.

CPT: Vest Click here to enter #.

Medication Administration: Enteral Tube ☐ IV Therapy ☐ Injections ☐ Port/PICC ☐

Nutrition: Enteral Tube Feed: Continuous ☐ or Frequency/# of hours if Intermittent Click here to enter frequency.

TPN: Continuous ☐ or Frequency/#of hours if Intermittent Click here to enter frequency/#.

Seizures: Frequency Click here to enter frequency# of Rescue Interventions in in a 14-day period: Click here to enter #.

Pressure Sores/Injuries: ☐ Stage I ☐ II ☐ III ☐ IV ☐ Unstageable

Ostomy/Catheter: Foley ☐ I/O Catheterization ☐ Nephrostomy ☐ Suprapubic Catheter ☐ Colostomy ☐ Ileostomy ☐

Dialysis: Hemodialysis ☐ Peritoneal ☐ Frequency (Weekly) Click here to enter frequency.

Functional Status: Total Dependence ☐ Extensive Assistance ☐

Other Pertinent Information:

MCO Medical Director Certification:

☐ I attest I have reviewed the submitted documentation and that the individual listed above meets the medically fragile criteria marked on this form.

_____ _____ _____

Signature – MCO Medical Director **Date** **Phone Number**

Printed Name of MCO Medical Director: _____

Specialty of Signing MCO Medical Director: _____