DIVISION OF SENIOR AND DISABILITIES SERVICES
MATERIAL IMPROVEMENT REPORTING
FOR ALI & APDD WAIVERS

Client Name: **Date of Review:**

Medicaid #: **Harmony ID #:**

Name of Assessor:

Skilled Level of Care Factors Unstable conditions requiring the care of licensed nursing personnel	**Comparison Assessment** (Met Level of Care)	**YES**	**NO**	**Current Assessment** (Denied Level of Care)	**YES**	**NO**	**Material Improvement Comments**
Intensive rehabilitative services as ordered by a physician and provided by a physical, occupational, respiratory or speech therapist five times per week or indicated by therapist.		☐	☐		☐	☐	
Review of direct services that require a home nurse, a licensed practical nurse or other personnel working under direct supervision of a registered nurse or licensed practical nurse who is on the premises when services are rendered.		☐	☐		☐	☐	
Medications: Drugs requiring intravenous or naso-gastric tube administration		☐	☐		☐	☐	
Colostomy-Ileostomy		☐	☐		☐	☐	
Gastrostomy		☐	☐		☐	☐	
Oxygen		☐	☐		☐	☐	
Tracheostomy		☐	☐		☐	☐	
Radiation therapy or cancer chemotherapy		☐	☐		☐	☐	
Sterile dressings requiring prescription medication		☐	☐		☐	☐	
Decubitus Ulcers		☐	☐		☐	☐	

Conditions that require skilled nursing facility (SNF) care until stabilization: • CVA • Fractured hip • Comatose • Terminal cancer • New myocardial infarction • Uncompensated congestive heart failure • Paraplegic quadriplegic		☐	☐		☐	☐	
Medications: Drugs requiring intravenous or naso-gastric tube administration		☐	☐		☐	☐	
Conditions which alone may not justify placement at the Skilled Level: • Diagnostic Procedures • Treatments • Behavioral Problems		☐	☐		☐	☐	

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Intermediate Level of Care Factors Chronic, with ongoing skilled needs at a lower frequency than SNF.	**Comparison Assessment** (Met Level of Care)	**YES**	**NO**	**Current Assessment** (Denied Level of Care)	**YES**	**NO**	**Material Improvement Comments**
Restorative services including encouraging patients to achieve independence in ADLs in self-care, transfer, ambulation, positioning and alignment, range of motion, use of handrails, positioning pillows, ambulation with or without assistive devices, assistance with or supervision of transfers.		☐	☐		☐	☐	
Performance of services that require a home nurse		☐	☐		☐	☐	
Medications		☐	☐		☐	☐	
Assistance with ADLs, including maintenance of Foley catheters, ostomies, supervision of special diets, and proper skin care of incontinent patients.		☐	☐		☐	☐	
Colostomy-Ileostomy		☐	☐		☐	☐	
Oxygen Therapy		☐	☐		☐	☐	
Radiation or Chemotherapy		☐	☐		☐	☐	
Skin Condition: decubitus ulcer or minor skin tears, abrasion, chronic skin conditions		☐	☐		☐	☐	
Diabetes: When daily observation of dietary intake and/or medication administration is required for proper physiological control.		☐	☐		☐	☐	
Behavioral problems: • wandering • verbal abuse • physical abuse • social inappropriate or disruptive behavior • inappropriate public sexual behavior or public disrobing • resists care • outbursts of anger		☐	☐		☐	☐	

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Assessment ADL Scores			
ADL	**Comparison Assessment** (Met Level of Care)	**Current Assessment** (Denied Level of Care)	**Comments**
Bed Mobility			
Transfers			
Locomotion			
Eating			
Toileting			

Review Comments:

Review Comments:

Review Comments:

What are the documents that SDS reviewed?

- ☐ All reasonably available records of visits in the last year to treating physicians listed on the assessment.
- ☐ *Verification of Diagnosis* forms submitted in the last year from physicians listed on the assessment.
- ☐ All reasonably available records of nursing care or other special treatments whether inpatient or outpatient received in the last year as indicated in the assessment.
- ☐ All reasonably available records of therapies received in the last year as indicated on the assessment.
- ☐ All known records from other residential stays including a nursing home, hospital, psychiatric institution, or assisted living home during the last year.
- ☐ All known records from other clinic or emergency room visits in the last year.
- ☐ The assessment for the most recent year you were found eligible for wavier services and the most recent assessment.
- ☐ Other:

Prepared by:

(Date) **(Signature or Electronic Signature of Assessor)**

(Printed Name of Assessor)

(Date) **(Signature of Reviewing RN)**

(Printed Name of Reviewing RN)