HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

New Mexico Human Services Department – Medical Assistance Division

Program of All-Inclusive Care for the Elderly (PACE) Long Term Care Medical Assessment

THIS INFORMATION IS CONFIDENTIAL

☐ Initial ☐ Reassessment Date Current LOC Expires: _____

A. General Patient Information

1. Patient Name (First, Middle Initial, Last):	2. Medicaid No. or SSN:	3. Date of Birth (00/00/0000):
4. Patient Mailing Address (Address, City, State, Zip Code):		5. Patient Phone #:
6. Authorized Representative Name (First and Last):		
7. Representative Mailing Address (Address, City, State, Zip Code):		8. Representative Phone #:

B. Activities of Daily Living (ADL) - *Patient must meet Nursing Facility Level of Care and functional level is such that <u>two or more</u> ADLs cannot be accomplished without consistent, ongoing, daily assistance.*

Activities of Daily Living	Independent	Assistance Required to Complete
1. Dressing……..	❑	❑
2. Bathing/Grooming……..	❑	❑
3. Eating……..	❑	❑
4. Meal Preparation……	❑	❑
5. Transfer……	❑	❑
6. Mobility……	❑	❑
7. Toileting……..	❑	❑
8. Bowel/Bladder……	❑	❑
9. Daily Medication (Self Administer)……..	❑	❑

C. Provider Information & Attestation – Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist

I attest that this patient's medical records support my diagnosis and recommendation for a Nursing Facility Level of Care.

1. Provider Printed Name (First and Last):	2. Provider Signature (Original or Electronic):	3. Date: (00/00/0000)
4. Provider Physical Address (Address, City, State, Zip Code):	5. Provider Phone #:	6. Provider Fax #:

D. TPA Utilization Review Section Only

1. TPA/UR Reviewer Initials (First and Last):	2. Review Date:	3. Review Status: ❑ Approved ❑ Denied
4. LOC Authorization #:	5. LOC Authorization Date Span (Begin Date – End Date):	
6. Additional Comments:		

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Form Instructions

PURPOSE: The Long Term Care Medical Assessment (MAD 379) is used to assess and issue prior approvals (PA) for Nursing Facility (NF) Level of Care (LOC) required for the Program of All-Inclusive Care for the Elderly (PACE). Medical providers (physician, nurse practitioner, physician assistant, or clinical nurse specialist) document activities of daily living (ADL) and attest that the medical records and recommendation are accurate and meet the NF LOC criteria. The patient's history and physical (H & P) is a required component to support documented information on this MAD 379. The H & P must include complete family and personal medical history and physical, and a complete list of medications in detail as necessary to manage the patient's present condition.

The completed MAD 379, H & P, and any supplemental documentation are reviewed by a Third Party Assessor (TPA) to determine if the patient meets the State's criteria for NF LOC. The MAD 379 indicates the approved LOC authorization number and NF LOC authorization date span. The MAD 379 is available on the NM Medicaid website or obtained upon request from the TPA. All information is confidential and sections A, B, and C, must be completed by the provider.

INSTRUCTIONS: Provider is to indicate if this is an Initial Assessment or Reassessment. Reassessments will note the date the current LOC expires.

A - General Patient Information: This contains patient identifying and contact information. In **box 1**, enter the patient's first, middle initial and last name. In **box 2**, enter the patient's Medicaid number or Social Security number. In **box 3**, enter the patient's date of birth. In **boxes 4 -5**, enter the patient's mailing address, city, state zip code and phone number. In **boxes 6-8**, enter the patient authorized representative's first and last name, mailing address and phone number.

B - Activities of Daily Living: Indicate and assess the patient's activities of daily living needs (ADL) by checking one of the following: "Independent" or "Assistance Required to Complete" for all ADL categories.

C - Provider Information & Attestation: The provider attests that the patient's medical records support the diagnosis and recommendation for NF LOC. In **box 1**, enter the provider's printed first and last name. In **box 2**, enter the provider's original or electronic signature. In **box 3**, enter the date of completion of this MAD 379. In **boxes 4-6**, enter the provider's physical address including city, state, zip code, provider phone number, and fax number. Note: The provider's use and submission of the electronic form constitutes the provider's signature, acceptance and agreement as if actually signed by them in writing. All parties using the form agree that no certification authority or other third party verification is necessary to validate the electronic signature; and the lack of such certification or third party verification will not in any way affect the enforceability of the signature or ability of the PACE Provider or TPA to complete related scopes of work.

D – TPA Utilization Review Section Only: The TPA completes all boxes**.** The TPA must send the completed MAD 379, inclusive of the NF LOC decision, to the PACE agency.

ROUTING:
If the MAD 379, H & P, or supplemental medical documentation is incomplete, the TPA will issue a Request for Information (RFI) to the PACE agency. If the TPA determines that the patient does not meet NF LOC, the TPA will send the referring parties a denial letter with the reason for denial as determined by the TPA Medical Director. Providers who disagree with the TPA's medical necessity decision(s) may request reconsideration within thirty (30) calendar days from the date of the denial letter (see 8.350.2 NMAC). Patients who disagree with the NF LOC denial can request a Fair Hearing within (90) calendar days of the date of the denial notice (see section 8.352.2 NMAC, Recipient Hearings.)

FORM RETENTION: Permanent.