



Section 14 - Special Documentation Requirements

**SECTION 14 - SPECIAL DOCUMENTATION REQUIREMENTS**

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### **SECTION 14-SPECIAL DOCUMENTATION REQUIREMENTS**

Program limits may require prior authorization or medical necessity. Reference Section 14.6 for specific requirements on medical necessity. Reference Section 7, Medical Necessity, and Section 8, Prior Authorization, for sample forms and general instructions on completing the forms.

Please be aware that when a specific 5-digit procedure code requires an attachment, and that same procedure code exists with a modifier, such as 50 bilateral, any attachment requirements applicable to the 5-digit code remain a requirement for the code with the modifier. Refer to the MO HealthNet fee schedule, for a list of the required attachment(s) for surgical procedures.

The MO HealthNet Program has requirements for other documentation when processing claims under certain circumstances. Refer to Sections 15, Billing Instructions, and 16, Medicare/MO HealthNet Crossover Claims, for further information. Refer to Sections 1-11 and 20 for general program documentation requirements.

#### **14.1 REQUIRED ATTACHMENTS**

When submitting claims requiring attachments, be sure to:

- include the correct attachment(s) for the service being billed (some procedures require more than one attachment).
- staple the attachment to the claim to which it applies.
- check that the name of the participant is the same on both the attachment and the claim.
- attach a legible copy if *not* submitting an original.
- check that all required information and signatures appear on the attachment.
- check that the dates of service are consistent with dates on the attachment.

##### **14.1.A RESUBMISSIONS**

When a claim requiring an attachment is resubmitted, *the provider must include a legible copy of the attachment with the resubmitted claim.* The fiscal agent *cannot* match the new submission to the attachment sent with the previous claim.

##### **14.1.B HOW TO ORDER ATTACHMENTS TO THE CLAIM FORM**

Required attachments to the claim form may be requested by completing the Forms Request.

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### **14.2 CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION**

The Certification of Medical Necessity for Abortion form is required for every abortion performed when the life of the mother would be endangered if the fetus were carried to term, as specified in Public Law 105-78 (1997), or if the pregnancy is the result of rape or incest. Refer to Section 13.40.I for additional information and specific guidelines on the abortion policy.

Refer to the MO HealthNet fee schedule for a list of procedures that require attachments.

#### **14.2.A INSTRUCTIONS FOR COMPLETING THE CERTIFICATION OF MEDICAL NECESSITY FOR ABORTION**

The fields on the form are self-explanatory. The Certification of Medical Necessity for Abortion form *must* be completed in full and the signature of the performing physician *must* be original. A signature by the performing physician's authorized representative is *not* acceptable. Medical documentation to support the information on the medical necessity form *must* be attached to the form. Claims for abortion services may *not* be billed electronically.

To order a supply of the Certification of Medical Necessity for Abortion forms, use the Forms Request or contact the Provider Relations Unit at (573) 751-2896.

### **14.3 ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION**

The Acknowledgement of Receipt of Hysterectomy Information form is required when a hysterectomy procedure is performed. This form is required regardless of the age of the woman. Information regarding hysterectomies is provided in Section 13.40.J. Refer to the MO HealthNet fee schedule, for the procedures that require attachments. It is the hospital's responsibility to obtain the necessary certification from the performing physician.

Hysterectomies are *not* to be reported as family planning services.

The (Sterilization) Consent Form *may not* be used instead of the Acknowledgement of Receipt of Hysterectomy Information form.

The paragraph at the bottom of the form indicates that it *must* be signed by the individual or her representative prior to the surgery, but there are no time limits. The Centers for Medicare & Medicaid (CMS) has given guidelines on this policy that in exceptional cases, the individual or her representative may sign the form after surgery if the patient or representative was informed of the hysterectomy procedure prior to the surgery.

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Instructions for completing the Acknowledgement of Receipt of Hysterectomy Information form. can be found on the back of the form.

### **14.3.A EXCEPTIONS TO THE ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION**

There are exception situations in which the Acknowledgement of Receipt of Hysterectomy Information form is *not* required; however, other physician certification is required in these situations, e.g., the Certificate of Medical Necessity form.

Exceptions to the requirement for an Acknowledgement of Receipt of Hysterectomy Information form may be made in the following situations:

- **The individual was already sterile before the hysterectomy.** The physician who performs the hysterectomy *must* certify in writing that the individual was already sterile at the time of the hysterectomy and *must* state the cause of the sterility. This *must* be documented by an operative report or admit and discharge summary attached to the claim for payment.
- **The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is *not* possible.** The physician *must* certify in writing to this effect and include a description of the nature of the emergency.
- **The individual was retroactively found MO HealthNet eligible for the period when surgery was performed.** If the provider is unable to obtain an eligibility approval letter from the participant, the claim may be submitted with a completed Certificate of Medical Necessity form indicating the participant was *not* eligible at the time of service, but has become eligible retroactively to that date. The physician who performed the hysterectomy *must* certify in writing that one of the following situations occurred:
  - The individual was informed before the operation that the hysterectomy will make her permanently incapable of reproducing and the procedure is *not* excluded from MO HealthNet coverage under "A";
  - The individual was already sterile before the hysterectomy; or
  - The hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was *not* possible. A description of the nature of the emergency *must* be included.



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### **14.4 (STERILIZATION) CONSENT FORM**

A (Sterilization) Consent Form *must* be attached to a claim whenever a voluntary sterilization procedure is performed. The (Sterilization) Consent Form has five copies. The bottom of the form shows the distribution. The physician should attach the white copy or a legible copy of the form to the claim. Refer to the MO HealthNet fee schedule for the procedures that require this attachment.

Refer to Section 10, Family Planning, for complete information concerning sterilization procedures. That section includes instructions for completing the form, exceptions to the required attachment and a completed (Sterilization) Consent Form.

### **14.5 INVOICE FOR MANUALLY PRICED PROCEDURES**

An invoice should be attached to the claim for payment of certain procedures that *must* be manually priced by the State Medical Consultant. As some procedures involve up-front costs to the provider for some material/supply, it is helpful if an invoice is attached outlining pertinent information regarding the material/supply. Refer to the MO HealthNet fee schedule, for procedures that require attachments.

The following are examples of procedures that *must* include an invoice.

PROC CODE	DESCRIPTION
J7190	Factor VIII (non-heat treated)  Always indicate "1" unit on the claim form and attach invoice showing the actual number of units.
J7194	Factor IX  Always indicate "1" unit on the claim form and attach invoice showing the actual number of units
A4261	Medical and Surgical Supplies (IUD/Diaphragm only)
A4641	Provision of Diagnostic Radionuclide(s)
A9699	Provision of Therapeutic Radionuclide(s)

Procedure codes ending in "99" are always manually priced and *must* include the information necessary for pricing by the state medical consultant.



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### **14.6 CERTIFICATE OF MEDICAL NECESSITY**

Certain services, procedures or circumstances require that a Certificate of Medical Necessity form be attached to a claim when it is submitted for payment. The service may be payable, if the Certificate of Medical Necessity form supports the need for the service or why another policy could *not* be followed.

Section 7 of this manual provides a full explanation of the purpose of this form, including instructions for completion and a sample form.

#### **14.6.A WHEN A CERTIFICATE OF MEDICAL NECESSITY IS REQUIRED**

The following *circumstances* require a Certificate of Medical Necessity form. Refer to the MO HealthNet fee schedule, for *procedures* that require a Certificate of Medical Necessity form.

##### **14.6.A(1) Private Hospital Room**

A private room is covered if there is a medical justification (e.g., infection control). A Certificate of Medical Necessity form *must* be completed by the physician and attached to the hospital claim explaining why a private room was necessary.

A private room is also covered if all patient rooms in a facility are private. The hospital provider *must* contact the Provider Enrollment Unit if all its rooms are private rooms. The attachment of a Certificate of Medical Necessity form is *not* required in this instance.

A private room is *not* covered if requested by the patient solely for the patient's convenience.

##### **14.6.A(2) Sonograms**

Claims for obstetrical sonograms exceeding three per participant, per rolling year *must* be accompanied by a properly completed Certificate of Medical Necessity form documenting the necessity of the additional procedures.

#### **14.6.B A CERTIFICATE OF MEDICAL NECESSITY FORM MAY BE USED INSTEAD OF THE REQUIRED ATTACHMENT**

There are situations that normally require specific policy documentation, but because of an unusual or emergency situation, a form can *not* be completed or is inappropriate for the situation. In these instances, a Certificate of Medical Necessity form *must* be completed fully describing the circumstances. The different types of circumstances are discussed below. Only the MO HealthNet Certificate of Medical Necessity form is acceptable.

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### **14.6.B(1) Definition of Emergency Services**

Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

### **14.6.B(2) Certificate of Medical Necessity in Lieu of a Second Surgical Opinion Form**

When a surgical procedure requiring a second opinion is performed as an emergency, a Certificate of Medical Necessity form, which states in detail the nature of the emergency, *must* be attached to the claim. Reference Section 14.7.B for further information.

### **14.6.B(3) Lock-In Participants**

Services provided to participants who are locked-in to a physician or hospital require a Medical Referral Form of Restricted Participant (PI-118) attachment from the lock-in physician or hospital unless the services are provided in response to an emergency situation. If emergency services are provided, a completed Certificate of Medical Necessity form that details the nature of the emergency *must* be attached to the claim when it is submitted for payment. Lock-in information is available on the interactive voice response (IVR) system or at [www.emomed.com](http://www.emomed.com) and should be verified along with the other eligibility information.

### **14.6.B(4) Procedures That Require Prior Authorization**

When procedures that require prior authorization are performed on an emergency basis, a Certificate of Medical Necessity form fully explaining the emergency situation *must* be attached to the claim.

### **14.6.C A CERTIFICATE OF MEDICAL NECESSITY MAY NOT BE USED FOR CERTAIN PROCEDURES**

A Certificate of Medical Necessity form *cannot* be used for procedures that require the (Sterilization) Consent Form or Acknowledgement of Receipt of Hysterectomy Information form when performed as an emergency procedure. Other documentation is required in this situation. Refer to Section 14.3 and 14.4.

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### **14.7 SECOND SURGICAL OPINION FORM**

The second surgical opinion policy is explained in detail in Section 13.30. Procedures that require the attachment of a Second Surgical Opinion Form are listed in the MO HealthNet fee schedule.

#### **14.7.A INSTRUCTIONS FOR COMPLETING THE SECOND SURGICAL OPINION FORM**

The Second Surgical Opinion Form is divided into four sections. Section 1 should be completed by the primary or first physician. Complete all fields. The patient should then take the form to the second physician who completes Section 2. *A second opinion must be obtained within 60 days after the first opinion.* The 60-day period begins with the appointment date shown in Section 1 and ends with the appointment date shown in Section 2. If the second physician does *not* agree with the primary physician and the patient wants a third opinion, then Section 3 should be completed by a third physician. *The third opinion must be obtained within 60 days of the second opinion.* Again, the appointment dates in Section 2 and Section 3 are the basis for determining the 60-day time period.

The physician who performs the surgery *must* retain the patient's medical records (history, laboratory data, x-rays, etc.) and the completed Second Surgical Opinion Form. If surgery is performed, Section 4 *must* be completed by the surgeon. *The surgery must be performed within 150 days after the primary recommendation.* The appointment date in Section 1 and the date of surgery in Section 4 are the fields that are reviewed to determine the 150-day period.

The surgeon is responsible for furnishing a copy of the Second Surgical Opinion Form to the hospital where the surgery was performed.

#### **14.7.B EXCEPTIONS TO SECOND SURGICAL OPINION FORM**

The following are exceptions to the second surgical opinion requirement.

- Medicare-MO HealthNet patients are exempt from this requirement provided Medicare makes the primary reimbursement and MO HealthNet makes reimbursement of the coinsurance and/or deductible amounts.
- Inpatient services are exempt if the participant has Medicare Part B but no Part A.
- The Second Surgical Opinion Form is *not* required if the surgeon does *not* participate in the MO HealthNet Program. The provider *must* submit a claim along with a Certificate of Medical Necessity form and indicate on the Certificate of Medical Necessity form the surgeon's full name and indicate "non-participating."



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- Surgical procedures that require a Second Surgical Opinion Form are exempt if they are performed incidental to a more major surgical procedure that does *not* require a second opinion.
- If the service was performed as an emergency and a second opinion could *not* be obtained prior to rendering the service, submit a claim along with a Certificate of Medical Necessity form indicating in detail the reason for the emergency provision.

Emergency requests are suspended and reviewed by a medical consultant. If the Certificate of Medical Necessity form is *not* attached, or the documentation does *not* substantiate the provision of the service on an emergency basis, the claim is denied.

- The participant was *not* eligible for MO HealthNet at the time of service, but was made retroactive to that time. If the provider is unable to obtain an eligibility approval letter from the participant, the claim may be submitted with a completed Certificate of Medical Necessity form indicating the participant was *not* eligible at the time of service, but has become eligible retroactively to that date. If the eligibility approval letter or the Certificate of Medical Necessity form is *not* submitted, the claim is denied. See Section 7 for instructions for completing the Certificate of Medical Necessity form.

### **14.8 ADMISSION CERTIFICATION FORMS**

All inpatient hospital admissions except pregnancy-related cases, deliveries and newborns require admission certification. Written or telephone contact *must* be made by the hospital, the admitting or attending physician to Health Care Excel (HCE). This procedure is explained in detail in Section 13.31 of the Hospital Manual. If the contact with HCE is in writing, three forms can be used depending on the circumstances: Preadmission, Postadmission, and one for circumstances in which the participant has already been discharged. The last one is titled Special Review Request and requires the submission of certain documentation as explained on the form.

Click on the form name for a sample of the MAIL/FAX Preadmission Certification Request, the FAX Post-Admission Urgent or Emergency Certification Request, and the Special Review Request.

### **14.9 CONTINUED STAY REVIEW**

HCE performs continued stay review throughout the hospitalization to ensure that each day of care is medically necessary and appropriate. This review is conducted on a prepayment review basis and is performed concurrently. If extended hospitalization is indicated beyond the initial LOS assigned by HCE, the hospital and attending physician are required to provide additional medical information to warrant the continued hospital stay as well as request the number of additional days needed. The



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additional days are requested by using the Continued Stay Fax Request Form. Reference Section 13.31 of the Hospital Manual for more information on continued stay review.

### **14.10 CERTIFICATION OF NEED FOR PSYCHIATRIC SERVICES (IM-71)**

Certification of need for inpatient psychiatric services is one of the requirements for the Inpatient Psychiatric Services for Individuals Under Age 21 Program. The IM-71 form was developed to assist providers in complying with this requirement. This form or a similar one developed by the hospital *must* be in the participant's medical record and a copy sent to the Family Support Division office in the participant's county of residence. This certification is required for *psychiatric hospitals* providing services to participants under 21 years of age. This certification *is not required* for acute care hospitals providing psychiatric care to participants under 21 years of age, even though the hospital may have a psychiatric unit exempt from Medicare Prospective Payment Systems (PPS).

The status of the child or youth at the time of admission determines whether an independent team or the facility's interdisciplinary team is responsible for certifying need for inpatient care.

Refer to Section 13.57 for a detailed explanation of this and other requirements for psychiatric services to children and youth under age 21 in a psychiatric hospital.

#### **14.10.A INSTRUCTIONS FOR COMPLETION OF CERTIFICATION OF NEED FOR PSYCHIATRIC SERVICES (IM-71)**

FIELD NUMBER AND NAME	INSTRUCTIONS FOR COMPLETION
1. Name of Patient	Enter name of individual.
2. Case Number	Enter participant's MO HealthNet Identification Number (DCN).
3. Date of Admittance	Enter the date the individual was admitted.
4. Name of JCAH Certified Facility	Enter the name of the hospital.
5. Physician Team Member	The physician and a member of the independent or interdisciplinary team <i>must</i> each sign and date the certification. The signatures <i>must</i> be original Include the title of the nonphysician team member.
6. Date	
7. Team Member/Title	
8. Date	



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- |                                  |  |
|----------------------------------|--|
| 9. Claimant's name or "myself"   | Enter participant's name if form is signed by a parent or guardian; enter "myself" if participant signs authorization for the release of information.            |
| 10. Authorize                    | Enter the name of the facility.  |
| 11. Month/Day/Year               | Enter the date of expiration of this authorization, normally <i>not</i> to exceed thirty days from date of signing.  |
| 12. Claimant, Parent or Guardian | The participant parent or guardian <i>must</i> sign and date the form. If parent or guardian signs here, state the relationship.                                 |
| 13. Date                         |  |
| 14. Relationship                 |  |
| 15- 20. Witness, Date, Address   | If participant is unable to sign his/her name, the signature may be made by mark. The signature, date, and address of two witnesses <i>must</i> then be entered. |

### **14.11 NURSING HOME FORMS**

The information on nursing home forms is important to physicians that *must* consider nursing home placement in the discharge plans of patients.

#### **14.11.A MISSOURI CARE OPTIONS (PRE-LONG-TERM CARE SCREENING [PLTC])**

There *must* be a PLTC screening for all admissions to a MO HealthNet bed for MO HealthNet eligible participants or MO HealthNet applicants. This screening can be as brief as a telephone call or as detailed as a face-to-face interview. A PLTC number *must* be requested from the Division of Senior Services and Regulation.

##### **14.11.A(1) DA-13**

Field #13 in Section A of the DA-124A/B *must* have a valid Pre-Long-Term-Care screening (PLTC) number entered there, which can be found on the DA-13. If the resident does *not* have a DA-13 form with that number when he/she is admitted to the facility, the nursing home *must* contact the Division of Senior Services and

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Regulation Hotline. That telephone number is (800) 392-0210. They give a PLTC number if one has already been assigned or begin the screening process in order to assign a number. The Family Support Division *cannot* authorize nursing home benefits if a screening number has *not* been assigned. If the nursing home admits a resident before a screening has taken place and an exemption is *not* met, the nursing home authorization for payment may be delayed.

### **14.11.B PREADMISSION SCREENING (PASRR)**

Section 13 discusses in detail the purpose and process of preadmission screening. Briefly, nursing homes are required to screen all applicants to Title XIX certified beds to determine if the individual is known or suspected to be mentally ill (MI), mentally retarded (MR) or developmentally disabled (DD). If the applicant is known or suspected to be MI, MR or DD and no special admissions category applies, he/she *cannot be admitted* to the certified bed until a determination on appropriate placement has been completed by the Department of Mental Health.

A Level I screening *must* be performed on all applicants to a certified bed in order to identify an individual suspected of being MI, MR or DD. The DA-124C form should be used to do the Level I screening. The form may be completed by a nursing home, hospital or physician.

- If the applicant is *not* known or suspected of being MI, MR or DD, he/she may be admitted to the facility. The DA-124C *must* be filed in the resident's medical records.
- If the applicant is suspected of being MI, MR or DD, form DA-124A/B *must* be completed.

The DA-124A/B and DA-124C *must* be sent to: COMRU, Division of Senior Services and Regulation, P.O. Box 1337, Jefferson City, MO 65102. *The person cannot be admitted* until a Level II screening is done, unless a special admissions category applies.

If a Level II evaluation is needed, the Notice to the Applicant *must* be given to the individual or his representative.

- MO HealthNet payments can begin no earlier than the date the physician signs the form or the date a Level II determination is made, if a Level II is needed.
- An applicant who is inappropriately admitted to a nursing facility according to the PASRR process *cannot* be held liable.

Instructions appear on the back of the form.

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### **14.11.C LEVEL OF CARE DETERMINATION**

#### **14.11.C(1) DA-124A/B FORM**

Eligibility for MO HealthNet nursing home benefits is based on MO HealthNet categorical eligibility, determined by the Family Support Division, and medical eligibility, determined by the Division of Senior Services and Regulation. These determinations of eligibility *must* be made before a MO HealthNet nursing home payment can be made on behalf of a participant. A medical consultant in the Division of Senior Services and Regulation makes the determination if the applicant for nursing home services needs nursing home level of care. The consultant's determination is based on the established guidelines found in state regulation 13 CSR 15-9.030 and the information given on the DA-124 forms.

The primary responsibility for providing the information on the forms belongs to the physician who signs it. These forms should be completed as fully as possible to allow the state consultant to make a valid determination. The forms may be typed or written legibly in ink. Be certain the information is clearly imprinted on all four copies.

Most of the information requested on these forms is self-explanatory and so only a few instructions are given. If providers have any questions concerning how to complete the forms, they may contact the Medical Review Unit at the Division of Senior Services and Regulation, (573) 751-3082. Forms that are *not* completed fully may be returned to the entity that submitted them. To avoid having the forms returned, providers should note the following instructions:

Section A, Field #11—Give the name of the facility where the resident will be residing.

Section A, Field #13—There *must* be a PLTC number (the “R” number).

Section B, Fields #1-4—The physical information should be indicated.

Section B, Field #6—Check this field if any of the incidents listed are applicable to the resident. Be sure to include dates and types, where appropriate.

Section B, Field #8—List the drugs ordered by the physician for the patient. The medications should be appropriate to the diagnoses shown in Field #9. Give the dosage and frequency.

Section B, Field #10 and 15—Specialized nursing services should be listed that support the assessed needs indicated in Field #40.



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Section B, Field #16—Completing the assessed needs field accurately is important in the determination of level of care. Be specific. For example, under “Mobility” to state, “Unable to ambulate,” is *not* specific. A statement such as, “Resident requires the assistance of two to transfer” or “Resident ambulates with assistance of one and walker,” is specific. Specificity under “Dietary” is, “Resident is on an 1800 calorie ADA diet and requires assistance to be fed” or “Resident needs set-up assistance but feeds self.” All nine areas of assessed needs should be answered in relation to the needs of one particular resident and the assistance required for that participant. Also indicate areas in which the resident is capable of being self sufficient, if any.

Section B, Field #19—The person filling out this form *must* sign and date it.

Section B, Field #12 and Section F of the DA-124C—This section *must* be completed, signed and dated by a physician. A rubber stamp or signature by the Director of Nursing is *not* accepted.

Forms that are completed with insufficient information or are *not* specific enough are returned to the sender. This delays processing the forms.

### **14.12 RISK APPRAISAL FOR PREGNANT WOMEN**

See Section 13.66 of the Physician's Manual for information on the Risk Appraisal for Pregnant Women.

**END OF SECTION**

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