State of Nebraska

Department of Health and Human Services

Serious and Complex Medical Conditions for Medically Frail Determinations

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Serious and Complex Conditions Overview

The purpose of this document is to provide information for health care providers and Heritage Health Adult beneficiaries to supplement the **Serious and Complex Medical Conditions** section of the Medically Frail attestation form. Beneficiaries who believe they meet the Medically Frail criteria are responsible for obtaining a Medically Frail attestation form, signed by a health care provider with diagnosing capabilities, within their Scope of Practice.

This document provides documentation guidelines and DHHS evaluation criteria for 14 different body system disorders including specific health disorders within each of the 14 body systems. Please refer to the table of contents for each body system.

DHHS may request follow-up information based on the information supplied by the health care provider or may deny Medically Frail determinations if the documentation included on the attestation form or other submitted documentation is incomplete or omits information outlined in this document.

DHHS may update this documentation at any time; therefore, it is recommended that health care providers refer to the most recent version of this document. This document will be posted to http://dhhs.ne.gov/pages/medically-frail.aspx.

1.0 Musculoskeletal System

Overview

DHHS evaluates disorders of the musculoskeletal system that may result from hereditary, congenital, or acquired pathologic processes. Impairments may result from infectious, inflammatory, or degenerative processes, traumatic or developmental events, or neoplastic, vascular, or toxic/metabolic diseases.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical evidence that documents the severity of the beneficiary's musculoskeletal disorder. Medical evidence may include diagnosis and evaluation of musculoskeletal impairments and should be supported, as applicable, by detailed descriptions of the joints, including ranges of motion, condition of the musculature (e.g., weakness, atrophy), sensory or reflex changes, circulatory deficits, and laboratory findings, including findings on x-ray or other appropriate medically acceptable imaging.
2. Medically acceptable imaging may include, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. "Appropriate" means that the technique used is the proper one to support the evaluation and diagnosis of the impairment. It is not necessary to submit actual imaging; radiologist imaging reports are sufficient in demonstrating support of the musculoskeletal disorder.
3. Musculoskeletal impairments frequently improve with time or respond to treatment. Assessment of the musculoskeletal disorder on the beneficiary's activities of daily living and that the disorder requires help for the beneficiary to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.
4. Exacerbations specific to the disorder (*primary diagnosis*) that results in inpatient hospitalization or frequent emergency department visits.
5. Assessment of the beneficiary's activities of daily living due to the disorder.

1.01 Major Dysfunction of a Joint(s) (due to any cause) – Characterized by gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:

Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in an extreme limitation of the ability to walk or interferes very seriously with an individual's ability to initiate,

sustain, or complete activities, or Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's musculoskeletal disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

1.02 Reconstructive surgery or surgical arthrodesis of a major weight- bearing joint(s) **–** Impacting beneficiary's activity(s) of daily living.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's musculoskeletal disorder (*primary diagnosis for PCP or specialist visit*).

AND

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

1.03 Disorders of the Spine – Limitations because of distortion of the bony and ligamentous architecture of the spine and associated impingement on nerve roots (including the cauda equina) or spinal cord. Such impingement on nerve tissue may result from a herniated nucleus pulposus, spinal stenosis, arachnoiditis, or other miscellaneous conditions (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's musculoskeletal disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

1.04 Amputation (Hand, Arm, Leg, and Foot) – Amputations due to any cause:

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's musculoskeletal disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

1.05 Amputation (Fingers or toes – Amputation due to a chronic disease. The attestation documentation must support that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's musculoskeletal disorder (*primary diagnosis for PCP or specialist visit*).

AND

B. Other body system disorder that caused the amputation of fingers and/or toes (e.g. diabetes, vascular disease or peripheral arterial disease)

OR

C. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

1.06 Fracture of the femur, tibia, pelvis, or one or more of the tarsal bones

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's musculoskeletal disorder, medical intervention and recovery (*primary diagnosis for PCP or specialist visit*).

AND

B. Activities of Daily Living Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

1.07 Fracture of an upper extremity – With nonunion of a fracture of the shaft of the humerus, radius, or ulna, under continuing surgical management.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's musculoskeletal disorder, medical intervention and recovery (*primary diagnosis for PCP or specialist visit*).

AND

B. Activities of Daily Living Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

1.08 Soft tissue injury (e.g., burns) – Upper or lower extremity, trunk, or face and head, under continuing surgical management.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's musculoskeletal disorder, medical intervention and recovery (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living - Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

1.09 Musculoskeletal Disorders that do not meet one of these listings – If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider should be submitted. The documentation included in the attestation must provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

2.0 Special Senses and Speech

Overview

Disorders of special senses and speech include visual disorders, visual impairment including blindness, loss of speech, and hearing disorders including hearing loss.

Hearing loss includes medically determinable impairment that causes hearing loss. Loss of speech includes the ability to produce speech by any means includes the use of mechanical or electronic devices that improve voice or articulation.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical evidence that documents the severity of hearing disorders. Medical evidence demonstrating a medically determinable impairment that causes vision or hearing loss. DHHS will consider documented diagnosis confirmed through follow-up office visits.

2. Exacerbations specific to the disorder (*primary diagnosis for PCP or specialist visit*) that results in inpatient hospitalization or frequent emergency department visits.

3. Assessment of the beneficiary's activities of daily living due to the impairment or disorder.

2.01 Loss of Central Visual Acuity – Remaining vision in the better eye after best correction interferes with daily activities that cannot be corrected with regular glasses, contact lenses, medicine or surgery.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's vision disorder (*primary diagnosis for PCP or specialist visit*) including date of loss of central visual acuity.

OR

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

2.02 Contraction of the visual field in the better eye – Remaining vision in the better eye after best correction interferes with daily activities that cannot be corrected with regular glasses, contact lenses, medicine or surgery.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the prior 12-month period due to the beneficiary's vision disorder (*primary diagnosis for PCP or specialist visit*) including date of contraction of visual field.

OR

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

2.03 Disturbance of labyrinthine-vestibular function (Including Ménière's disease) – Characterized by a history of frequent attacks of balance disturbance, tinnitus, and progressive loss of hearing. Recurring episodes of vertigo that begins and ends spontaneously. Episodes of severe vertigo occur without warning causing nausea, vomiting and loss of balance.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's vertigo or loss of balance disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's special senses and speech disorder.

2.04 Loss of speech due to any cause – With inability to produce by any means speech that can be heard, understood, or sustained.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's speech disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Loss of speech is significant (more than acute loss of speech, e.g. laryngitis or without voice for a week). Submit documentation including the duration of the beneficiary's loss of speech and expected duration for speech loss.

2.05 Hearing loss not treated with cochlear implantation

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's speech disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Hearing loss that results in less than 90 decibels or impairs the beneficiaries cognitive functioning including social communication.

OR

C. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

2.06 Hearing loss treated with cochlear implantation.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's speech disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Considered to be Medically Frail for one year if received cochlear implant within the 6 months prior to the Medically Frail review. Submit documentation verifying date of implant.

2.07 *Special Senses and Speech Disorders that do not meet one of these listings* – If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider should be submitted. The documentation included in the attestation must provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

3.0 Respiratory Disorders

Overview

We evaluate respiratory disorders that result in obstruction (difficulty moving air out of the lungs) or restriction (difficulty moving air into the lungs), or that interfere with diffusion (gas exchange) across cell membranes in the lungs. Examples of such disorders and the listings we use to evaluate them include chronic obstructive pulmonary disease (chronic bronchitis and emphysema), pulmonary fibrosis and pneumoconiosis, asthma, and bronchiectasis. We also use listings in this body system to evaluate respiratory failure, chronic pulmonary hypertension, and lung transplantation.

Cancers affecting the respiratory system are evaluated under the listings in **13.0 (Cancer)**. Pulmonary effects of neuromuscular and autoimmune disorders are evaluated under these listings or under the listings in **11.0 (Neurological)** or **14.0 (Immune)**, respectively.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical evidence that documents the severity of the beneficiary's respiratory disorder. Medical evidence may include medical history, physical examination findings, summary results of medically appropriate imaging, pulmonary function tests, 6 minute walk test, other relevant laboratory tests, and descriptions of any prescribed treatment and he beneficiary's response to it.
2. Document any effects of the beneficiary's obesity that may be associated with the beneficiary's respiratory disorder(s).
3. Exacerbations specific to the disorder (*primary diagnosis*) that results in inpatient hospitalization or frequent emergency department visits.
4. Assessment of the beneficiary's activities of daily living due to the disorder.

3.01 Chronic respiratory disorders due to any cause except Cystic Fibrosis

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's respiratory disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's respiratory disorder.

3.02 Asthma. Asthma is a chronic inflammatory disorder of the lung airways.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's respiratory disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's respiratory disorder.

3.03 Bronchiectasis. Bronchiectasis is a chronic respiratory disorder that is characterized by abnormal and irreversible dilatation (enlargement) of the airways below the trachea, which may be associated with the accumulation of mucus, bacterial infections, and eventual airway scarring. Imaging reports are required to document this disorder.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's respiratory disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's respiratory disorder.

3.04 Chronic pulmonary hypertension. Chronic pulmonary hypertension is an increase in the blood pressure of the blood vessels of the lungs. If pulmonary hypertension is not adequately treated, it can eventually result in right heart failure. Chronic pulmonary hypertension is typically diagnosed by catheterization of the pulmonary artery.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's respiratory disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's respiratory disorder.

3.05 Lung transplantation.

Required Documentation

A. If the beneficiary receives a lung transplant (or a lung transplant simultaneously with other organs, such as the heart), we will consider the beneficiary Medically Frail for 3 years from the date of the transplant.

OR

B. If the beneficiary is on the United Network for Organ Sharing (UNOS) waiting list for a transplant, we will consider the beneficiary to be Medically Frail from the date the beneficiary is added to the waiting list. The beneficiary or health care provider can supply verification that the beneficiary is on a transplant waiting list.

3.06 Respiratory failure – Respiratory failure is the inability of the lungs to perform their basic function of gas exchange. If the beneficiary has respiratory failure due to any other chronic respiratory disorder. Continuous positive airway pressure does not satisfy the criterion and cannot be substituted as an equivalent finding, for invasive mechanical ventilation or noninvasive ventilation with BiPAP.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's respiratory failure (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's respiratory disorder.

3.07 Sleep-related breathing disorders – For example, sleep apnea is characterized by transient episodes of interrupted breathing during sleep, which disrupt normal sleep patterns. Prolonged episodes can result in disorders such as hypoxemia (low blood oxygen) and pulmonary vasoconstriction (restricted blood flow in pulmonary blood vessels). Over time, these disorders may lead to chronic pulmonary hypertension or other complications.

Complications of sleep-related breathing disorders are evaluated under the affected body system(s). For example, we evaluate chronic pulmonary hypertension due to any cause under **3.0 (Respiratory)**; chronic heart failure under **4.0 (Cardiovascular)**; and disturbances in mood, cognition, and behavior under **12.0 (Mental)** or another appropriate mental disorders listing.

3.08 Mycobacterial, mycotic, and other chronic infections of the lungs – DHHS evaluates chronic infections of the lungs that result in limitations in respiratory function.

Required Documentation

A. Multiple documented respiratory infections from any underlying chronic respiratory disorder, three times within a 12-month period and at least 30 days apart (*primary diagnosis for PCP or specialist visit*).

OR

B. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's chronic lung infections (*primary diagnosis for PCP or specialist visit*).

OR

C. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

D. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

E. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's respiratory disorder.

3.09 Respiratory Disorders that do not meet one of these listings – If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider should be submitted. The documentation included in the attestation must provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

4.0 Cardiovascular Disorders

Overview

Cardiovascular impairment includes any disorder, congenital or acquired, that affects the proper functioning of the heart or the circulatory system (that is, arteries, veins, capillaries, and the lymphatic drainage).

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical evidence that documents the severity of the beneficiary's cardiovascular disorder. Medical evidence may include diagnosis and evaluation (laboratory studies, summary results of medical imaging, ultrasound/echocardiograph timely cardiovascular tests (ECG's, exercise tests, and exercise tolerance tests)), and any prescribed treatment and response to allow DHHS to assess the severity and duration of the beneficiary's cardiovascular impairment.
2. Exacerbations of the cardiovascular disorder resulting in inpatient hospitalization or frequent emergency department visits.
3. Assessment of the disorder on the beneficiary's activities of daily living and that the disorder requires help for the beneficiary to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

4.01 Chronic Heart Failure – The inability of the heart to pump enough oxygenated blood to body tissues. This syndrome is characterized by symptoms and signs of pulmonary or systemic congestion (fluid retention) or limited cardiac output. Certain laboratory findings of cardiac functional and structural abnormality support the diagnosis of CHF. There are two main types of CHF: predominant systolic dysfunction and predominant diastolic dysfunction.

Required Documentation

A. 3 or more visits to primary care physician or specialist including summary results of appropriate medical imaging (pulmonary vascular markings, pleural effusion and pulmonary edema) over the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

D. Activities of Daily Living – Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

4.02 Ischemic Heart Disease – When at least one coronary artery is narrowed or obstructed or, in rare situations, constricted due to vasospasm, interfering with the normal flow of blood to the heart muscle (ischemia). The obstruction may be the result of an embolus, a thrombus, or plaque. When heart muscle tissue dies because of the reduced blood supply, it is called a myocardial infarction (heart attack).

Required Documentation

A. 3 or more visits to primary care physician or specialist including summary results of appropriate medical imaging, ultrasound, or echocardiography over the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

D. Activities of Daily Living – Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

4.03 Recurrent Arrhythmias – A change in the regular beat of the heart. The heart may seem to skip a beat or beat irregularly, very quickly (tachycardia), or very slowly (bradycardia).

Required Documentation

A. 3 or more visits to primary care physician or specialist including summary results of appropriate medical imaging, ultrasound, or echocardiography over the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

D. Activities of Daily Living Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

4.04 Symptomatic congenital heart disease (Atrial Septal defect, Atrioventricular Septal defect, Patent Formen Ovale, and Ventricular Septal defect)

Required Documentation

A. 3 or more visits to primary care physician or specialist including summary results of appropriate medical imaging and/or cardiac testing over a 12-month period due to the beneficiary's cardiovascular disorder.

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department visit in the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

D. Activities of Daily Living Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

***4.05 Heart transplant*.**

Required Documentation

A. If the beneficiary receives a heart transplant (or a heart transplant simultaneously with other organs, such as the lungs), we will consider the beneficiary Medically Frail for 3 years from the date of the transplant.

OR

B. If the beneficiary is on the United Network for Organ Sharing (UNOS) waiting list for a transplant, we will consider the beneficiary to be Medically Frail from the date the beneficiary is added to the waiting list. The beneficiary or health care provider can supply verification that the beneficiary is on a transplant waiting list.

***4.06 Aneurysm of aorta or major branches*,** due to any cause (e.g., atherosclerosis, cystic medial necrosis, Marfan syndrome, trauma),

Required Documentation

A. 3 or more visits to primary care physician or specialist including summary results of appropriate medical imaging, medically acceptable imaging, with dissection not controlled by prescribed treatment over the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

D. Activities of Daily Living Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

***4.07 Chronic venous insufficiency* of a lower extremity with incompetency or obstruction of the deep venous system.**

Required Documentation

A. 3 or more visits to primary care physician or specialist including summary results of appropriate medical imaging, medically acceptable imaging, prescribed treatment over the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

D. Activities of Daily Living Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

4.08 Peripheral arterial disease

Required Documentation

A. 3 or more visits to primary care physician or specialist including summary results of appropriate medical imaging, medically acceptable imaging, prescribed treatment over the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's cardiovascular disorder.

OR

D. Activities of Daily Living Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

4.09 Cardiovascular Disorders that do not meet one of these listings – If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider should be submitted. The documentation included in the attestation must provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

5.0 Digestive System Disorders

Overview

Disorders of the digestive system include gastrointestinal hemorrhage, hepatic (liver) dysfunction, inflammatory bowel disease, short bowel syndrome, and malnutrition. They may also lead to complications, such as obstruction, or be accompanied by manifestations in other body systems.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical evidence that documents the severity of the beneficiary's digestive system disorder. Medical evidence may include medical history, physical examination finding, summary imaging reports, and other relevant laboratory tests that.
2. Exacerbations of the digestive disorder resulting in inpatient hospitalization or frequent emergency department visits, (*if applicable*).
3. Assessment of the beneficiary's activities of daily living due to the disorder.

5.01 Gastrointestinal hemorrhaging from any cause

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's digestive disorder and/or blood transfusion associated with gastrointestinal hemorrhaging (*primary diagnosis for PCP or specialist visit*).

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department visits in the last 12-month period due to the beneficiary's digestive disorder.

5.02 Chronic Liver Disease *– May include:*

1. Hemorrhaging from esophageal, gastric, or ectopic varices or from portal hypertensive gastropathy
2. Ascites or hydrothorax not attributable to other causes, despite continuing treatment as prescribed by physician
3. Spontaneous bacterial peritonitis
4. Hepatopulmonary syndrome

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's digestive disorder including summary findings of medically acceptable imaging, (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's digestive disorder.

5.03 Inflammatory bowel disease

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's digestive disorder including summary findings of medically acceptable imaging, (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's digestive disorder.

5.04 Short bowel syndrome

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's digestive disorder including summary findings of medically acceptable imaging, (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's digestive disorder.

OR

E. The beneficiary is receiving total parenteral nutrition.

5.05 Weight loss due to any digestive disorder

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's digestive disorder including summary findings of medically acceptable imaging, (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's digestive disorder.

5.06 Liver transplantation

A. If the beneficiary receives a liver transplant, we will consider the beneficiary to be Medically Frail for 3 years from the date of the transplant.

OR

B. If the beneficiary is on the United Network for Organ Sharing (UNOS) waiting list for a transplant, we will consider the beneficiary to be Medically Frail from the date the beneficiary is added to the waiting list. The beneficiary or health care provider can supply verification that the beneficiary is on a transplant waiting list.

5.07 Digestive System Disorders that do not meet one of these listings If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider should be submitted. The documentation included in the attestation must provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

6.0 Genitourinary Disorders

Overview

DHHS evaluates genitourinary disorders resulting in chronic kidney disease. Examples of such disorders include chronic glomerulonephritis, hypertensive nephropathy, diabetic nephropathy, chronic obstructive uropathy, and hereditary nephropathies. DHHS also evaluates nephrotic syndrome due to glomerular dysfunction under these listings.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical evidence that documents the severity of the beneficiary's chronic kidney disease. Medical evidence should include medical history, physical examination findings, the results of imaging, clinical evaluations, other relevant laboratory test findings, and descriptions of any prescribed treatment and the beneficiary's response to it.
2. Exacerbations specific to the disorder (*primary diagnosis*) that results in inpatient hospitalization or frequent emergency department visits.
3. Assessment of the beneficiary's activities of daily living due to the disorder.

6.01 Chronic Kidney Disease with Kidney Transplant

Required Documentation

A. If the beneficiary receives a kidney transplant, DHHS will consider the beneficiary Medically Frail for 3 years from the date of the transplant.

OR

B. If the beneficiary is on the United Network for Organ Sharing (UNOS) waiting list for a transplant, we will consider the beneficiary to be Medically Frail from the date the beneficiary is added to the waiting list. The beneficiary or health care provider can supply verification that the beneficiary is on a transplant waiting list.

6.02 Chronic Kidney Disease with Impairment of Kidney Function

Required Documentation for Beneficiaries on Dialysis *and Not Covered by Medicare*

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's chronic kidney disease disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Physician documented dialysis (hemodialysis or peritoneal) required outside an acute setting and recurring on an ongoing basis.

OR

C. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

Required Documentation for Beneficiaries with Chronic Kidney Disease without Dialysis

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's chronic kidney disease disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's genitourinary disorder.

OR

D. Activities of Daily Living Assessment that the the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

6.03 Complications of Chronic Kidney Disease

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's chronic kidney disease disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's genitourinary disorder.

6.04 Chronic kidney disease Disorders that do not meet one of these listings – If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider should be submitted. The documentation included in the attestation must provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

7.0 Hematological Disorders

Overview

DHHS evaluates non-malignant (non-cancerous) hematological disorders, such as hemolytic anemias, disorders of thrombosis and hemostasis, and disorders of bone marrow failure. These disorders disrupt the normal development and function of white blood cells, red blood cells, platelets, and clotting-factor proteins (factors).

DHHS evaluates malignant (cancerous) hematological disorders, such as lymphoma, leukemia, and multiple myeloma, under the appropriate listings in **13.0 (Cancer)**, except for two lymphomas associated with human immunodeficiency virus (HIV) infection. DHHS evaluates primary central nervous system lymphoma associated with HIV infection and primary effusion lymphoma associated with HIV infection under **14.0 (Immune)**.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical evidence that documents the severity of the beneficiary's hematological disorder. Medical evidence may include medical history, physical examination findings, the results of laboratory tests, and descriptions of any prescribed treatment and the beneficiary's response to it.
2. Exacerbations specific to the disorder (*primary diagnosis*) that results in inpatient hospitalization or frequent emergency department visits.
3. Assessment of the beneficiary's activities of daily living due to the disorder.

7.01 Disorders of thrombosis and hemostasis including hemophilia and thrombocytopenia

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's hematological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's hematological disorder.

7.02 Disorders of bone marrow failure, including myelodysplastic syndromes, aplastic anemia, granulocytopenia, and myelofibrosis

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's hematological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living Assessment: Beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's hematological disorder.

7.03 Hematological disorders treated by transplant.

A. If the beneficiary receives a transplant (e.g. bone marrow or stem cell), DHHS will consider the beneficiary Medically Frail for 3 years from the date of the transplant.

OR

B. If the beneficiary is on the United Network for Organ Sharing (UNOS) waiting list for a transplant, we will consider the beneficiary to be Medically Frail from the date the beneficiary is added to the waiting list. The beneficiary or health care provider can supply verification that the beneficiary is on a transplant waiting list.

7.04 Repeated complications of hematological disorders or other complications **–** For example, anemia, osteonecrosis, retinopathy, skin ulcers, silent central nervous system infarction, cognitive or other mental limitation, or limitation of joint movement), resulting in significant, documented symptoms or signs evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight. If beneficiary meets (A.) or (B.) or (C.) they must meet (D.) otherwise if the beneficiary meets (D.) only they meet the criteria.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's hematological disorder (*primary diagnosis for PCP or specialist visit*).

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

C. 2 or more visits to an emergency department in the last 12-month period due to the beneficiary's hematological disorder.

D. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

7.05 Hematological Disorders that do not meet one of these listings – If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider should be submitted. The documentation included in the attestation must provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

8.0 Skin Disorders

Overview

We use these listings to evaluate skin disorders that may result from hereditary, congenital, or acquired pathological processes. The kinds of impairments covered by these listings are: Ichthyosis, bullous diseases, chronic infections of the skin or mucous membranes, dermatitis, hidradenitis suppurativa, genetic photosensitivity disorders, and burns. Cancers affecting the skin are evaluated under the listings in **10.0 (Cancer)**.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical evidence that documents the severity of the beneficiary's respiratory disorder. Medical evidence may include medical history, physical examination findings, laboratory / pathology findings including biopsy) and descriptions of any prescribed treatment, including duration and the beneficiary's response to it including any adverse effects.
2. Health care providers should document onset, duration, frequency of flare-ups, and prognosis of skin disorder; the location, size, and appearance of lesions; and, when applicable, history of exposure to toxins, allergens, or irritants, familial incidence, seasonal variation, stress factors, and ability to function outside of a highly protective environment.
3. Assessment of the beneficiary's activities of daily living due to the disorder.

8.01 Ichthyosis – With extensive skin lesions that persist for at least 2 months or longer despite continuing treatment as prescribed.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's skin disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department visit in the last 12-month period due to the beneficiary's skin disorder.

AND

D. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

8.02 Bullous disease – With extensive skin lesions that persist for at least 2 months or longer despite continuing treatment as prescribed.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's skin disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department visit in the last 12-month period due to the beneficiary's skin disorder.

AND

D. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

8.03 Chronic infections of the skin or mucous membranes – With extensive fungating or extensive ulcerating skin lesions that persist for at least 2 months or longer despite continuing treatment as prescribed.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's skin disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department visit in the last 12-month period due to the beneficiary's skin disorder.

AND

D. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

8.04 Dermatitis – With extensive skin lesions that persist for at least 2 months or longer despite continuing treatment as prescribed.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's skin disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department visit in the last 12-month period due to the beneficiary's skin disorder.

AND

D. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

8.05 Hidradenitis Suppurativa – With extensive skin lesions involving both axillae, both inguinal areas, or the perineum that persist for at least 2 months or longer despite continuing treatment as prescribed.

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's skin disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department visit in the last 12-month period due to the beneficiary's skin disorder.

AND

D. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

8.06 Genetic photosensitivity disorders

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's skin disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department visit in the last 12-month period due to the beneficiary's skin disorder.

AND

D. Functional ability outside of a highly protective environment for a continuous period of at least 2 months.

8.07 Burns – With extensive skin lesions that have lasted or can be expected to last for a continuous period of at least 2 months

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's skin disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

C. 2 or more visits to an emergency department visit in the last 12-month period due to the beneficiary's skin disorder.

AND

D. Activities of Daily Living – Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

8.08 Skin Disorders that do not meet one of these listings – If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider should be submitted. The documentation included in the attestation must provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

9.0 Endocrine Disorders

Overview

An endocrine disorder is a medical condition that causes a hormonal imbalance. When an endocrine gland functions abnormally, producing either too much of a specific hormone (hyperfunction) or too little (hypofunction), the hormonal imbalance can cause various complications in the body. The major glands of the endocrine system are the pituitary, thyroid, parathyroid, adrenal, and pancreas.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

Endocrine disorders may impact medical frail determinations for other body systems included in the complex and serious Medically Frail conditions. For example:

1. DHHS requires medical evidence that documents the severity of the beneficiary's endocrine disorder. Medical evidence may include medical history, physical examination findings, the results of imaging, pulmonary function tests, other relevant laboratory tests, and descriptions of any prescribed treatment and he beneficiary's response to it.
2. Pituitary gland disorders can disrupt hormone production and normal functioning in other endocrine glands and in many body systems. For example, when pituitary hypofunction affects water and electrolyte balance in the kidney and leads to diabetes insipidus, we evaluate the effects of recurrent dehydration under **6.0 (Genitourinary)**.
3. Thyroid gland disorders affect the sympathetic nervous system and normal metabolism. We evaluate thyroid-related changes in blood pressure and heart rate that cause arrhythmias or other cardiac dysfunction under **4.0 (Cardiovascular)**; thyroid-related weight loss under **5.0 (Digestive)**; hypertensive cerebrovascular accidents (strokes) under **11.0 (Neurological)**; and cognitive limitations, mood disorders, and anxiety under **12.0 (Mental)**.
4. Parathyroid gland disorders affect calcium levels in bone, blood, nerves, muscle, and other body tissues. We evaluate parathyroid-related osteoporosis and fractures under **1.0 (Musculoskeletal)**; abnormally elevated calcium levels in the blood (hypercalcemia) that lead to cataracts under **2.0 (Special Senses and Speech)**; kidney failure under **6.0 (Genitourinary)**; and recurrent abnormally low blood calcium levels (hypocalcemia) that lead to increased excitability of nerves and muscles, such as tetany and muscle spasms, under **11.0 (Neurological)**.
5. Adrenal gland disorders affect bone calcium levels, blood pressure, metabolism, and mental status. We evaluate adrenal-related osteoporosis with fractures that compromises the ability to walk or to use the upper extremities under **1.0 (Musculoskeletal)**; adrenal-related hypertension that worsens heart failure or causes recurrent arrhythmias under **4.0 (Cardiovascular)**; adrenal-related weight loss under **5.0 (Digestive)**; and mood disorders under **12.0 (Mental)**.

6. Diabetes mellitus and other pancreatic gland disorders disrupt the production of several hormones, including insulin, that regulate metabolism and digestion. There are two major types of DM: type 1 and type 2. Both type 1 and type 2 DM are chronic disorders that can have serious disabling complications that meet the duration requirement. Type 1 DM--previously known as "juvenile diabetes" or "insulin-dependent diabetes mellitus" (IDDM)--is an absolute deficiency of insulin production that commonly begins in childhood and continues throughout adulthood. Treatment of type 1 DM always requires lifelong daily insulin. With type 2 DM--previously known as "adult-onset diabetes mellitus" or "non-insulin-dependent diabetes mellitus" (NIDDM)--the body's cells resist the effects of insulin, impairing glucose absorption and metabolism. Treatment of type 2 DM generally requires lifestyle changes, such as increased exercise and dietary modification, and sometimes insulin in addition to other medications. While both type 1 and type 2 DM are usually controlled, some persons do not achieve good control for a variety of reasons including, but not limited to, hypoglycemia unawareness, other disorders that can affect blood glucose levels, inability to manage DM due to a mental disorder, or inadequate treatment.

    a. Hyperglycemia. Both types of DM cause hyperglycemia, which is an abnormally high level of blood glucose that may produce acute and long-term complications. Acute complications of hyperglycemia include diabetic ketoacidosis. Long-term complications of chronic hyperglycemia include many conditions affecting various body systems.

        i. Diabetic ketoacidosis (DKA). DKA is an acute, potentially life-threatening complication of DM in which the chemical balance of the body becomes dangerously hyperglycemic and acidic. It results from a severe insulin deficiency, which can occur due to missed or inadequate daily insulin therapy or in association with an acute illness. It usually requires hospital treatment to correct the acute complications of dehydration, electrolyte imbalance, and insulin deficiency. You may have serious complications resulting from treatment, which we evaluate under the affected body system. For example, we evaluate cardiac arrhythmias under **4.0 (Cardiovascular)**, intestinal necrosis under **5.0 (Digestive)**, and cerebral edema and seizures under **11.0 (Neurological)**. Recurrent episodes of DKA may result from mood or eating disorders, which we evaluate under **12.0 (Mental)**.

        ii. Chronic hyperglycemia. Chronic hyperglycemia, which is longstanding abnormally high levels of blood glucose, leads to long-term diabetic complications by disrupting nerve and blood vessel functioning. This disruption can have many different effects in other body systems. For example, we evaluate diabetic peripheral neurovascular disease that leads to gangrene and subsequent amputation of an extremity under **1.0 (Musculoskeletal)**; diabetic retinopathy under **2.0 (Special Senses and Speech)**; coronary artery disease and peripheral vascular disease under **4.0 (Cardiovascular)**; diabetic gastroparesis that results in abnormal gastrointestinal motility under **5.0 (Digestive)**; diabetic

nephropathy under **6.0 (Genitourinary)**; poorly healing bacterial and fungal skin infections under **8.0 (Skin)**; diabetic peripheral and sensory neuropathies under **11.0 (Neurological)**; and cognitive impairments, depression, and anxiety under **12.0 (Mental)**.

b. Hypoglycemia. Persons with DM may experience episodes of hypoglycemia, which is an abnormally low level of blood glucose. Most adults recognize the symptoms of hypoglycemia and reverse them by consuming substances containing glucose; however, some do not take this step because of hypoglycemia unawareness. Severe hypoglycemia can lead to complications, including seizures or loss of consciousness, which we evaluate under **11.0 (Neurological)**, or altered mental status and cognitive deficits, which we evaluate under **12.0 (Mental)**.

9.01 Endocrine Disorders that do not meet one of these listings – If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider should be submitted. The documentation included in the attestation must provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

10.0 Congenital Disorders that Affect Multiple Body Systems

Overview

Congenital disorders represent mosaic and non-mosaic Down syndrome under this body system. Most people with non-mosaic Down syndrome have three copies of chromosome 21 in all their cells (chromosome 21 trisomy); some have an extra copy of chromosome 21 attached to a different chromosome in all of their cells (chromosome 21 translocation). Virtually all people with non-mosaic Down syndrome have characteristic facial or other physical features, delayed physical development, and intellectual disability. People with non-mosaic Down syndrome may also have congenital heart disease, impaired vision, hearing problems, and other disorders. If you the beneficiary has mosaic, non-mosaic or translocation Down syndrome documented, we consider you Medically Frail since. DHHS's list of Medically Frail ICD-10 diagnosis codes includes Down Syndrome.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires physician documented diagnosis (ICD-10) for mosaic, non-mosaic or translocation Down syndrome.

10.01 Mosaic, non-mosaic or translocation Down syndrome

Required Documentation

A. Provider attestation that the beneficiary has Down syndrome, chromosome 21 trisomy or chromosome 21 translocation.

OR

B. Historical claim data indicating the appropriate ICD-10 for Down syndrome, chromosome 21 trisomy or chromosome 21 translocation.

10.02 Other congenital disorders that affect multiple body systems. Other congenital disorders, such as congenital anomalies, chromosomal disorders, dysmorphic syndromes, inborn metabolic syndromes, and perinatal infectious diseases, can cause deviation from, or interruption of, the normal function of the body or can interfere with development. Examples of these disorders include both the juvenile and late-onset forms of Tay-Sachs disease, trisomy X syndrome (XXX syndrome), fragile X syndrome, phenylketonuria (PKU), caudal regression syndrome, and fetal alcohol syndrome. For these disorders and other disorders like them, the degree of deviation, interruption, or interference, as well as the resulting functional limitations and their progression, may vary widely from person to person and may affect different body systems. The documentation included in the attestation should provide

evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

11.0 Neurological Disorders

Overview

DHHS evaluates epilepsy, amyotrophic lateral sclerosis, coma or persistent vegetative state (PVS), and neurological disorders that cause disorganization of motor function, bulbar and neuromuscular dysfunction, communication impairment, or a combination of limitations in physical and mental functioning such as early-onset Alzheimer's disease. DHHS evaluates neurological disorders that may manifest in a combination of limitations in physical and mental functioning. For example, if the beneficiary has a neurological disorder that causes mental limitations, such as Huntington's disease, which may limit executive functioning (e.g., regulating attention, planning, inhibiting responses, decision-making), DHHS evaluates the beneficiary's limitations using the functional criteria under these listings. Under this body system, DHHS evaluates the limitations resulting from the impact of the neurological disease process itself. If the beneficiary's neurological disorder results in only mental impairment or a co-occurring mental condition not caused by the neurological disorder (for example, dementia), DHHS will evaluate the beneficiary's mental impairment under the mental disorders body system, **12.0 (Mental Disorders)**.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical that documents the severity of the beneficiary's neurological disorder. Medical evidence may include medical history, physical examination findings, the results of clinically appropriate imaging, and laboratory tests.
2. Imaging must be consistent with the prevailing state of medical knowledge and clinical practice as the proper technique to support the evaluation of the disorder. It is not necessary to submit actual imaging; radiologist imaging reports are sufficient in demonstrating support of the neurological disorder.
3. Assessment of the beneficiary's activities of daily living due to the disorder.

11.01 Epilepsy – Documented by a detailed description of a typical seizure

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's neurological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Dyscognitive seizures, generalized tonic-seizures or dyscognitive seizures occurring despite the beneficiary's adherence to prescribed treatment the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

11.02 Vascular Insult to the Brain

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's neurological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented sensory or motor aphasia resulting in ineffective speech or communication that significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

OR

C. Activities of Daily Living - Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

11.03 **Benign brain tumors**

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's neurological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented disorganization of motor function that significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

OR

C. Activities of Daily Living - Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

11.04 Parkinsonian Syndrome

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's neurological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented disorganization of motor function that significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

OR

C. Activities of Daily Living - Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

11.05 Spinal Cord Disorders

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's neurological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented disorganization of motor function that significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

OR

C. Activities of Daily Living - Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

11.06 Post-Polio Syndrome

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's neurological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented disorganization of motor function that significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

OR

C. Activities of Daily Living - Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

11.07 Myasthenia Gravis

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's neurological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented disorganization of motor function that significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

OR

C. Activities of Daily Living - Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

11.08 Peripheral Neuropathy

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's neurological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented disorganization of motor function that significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

OR

C. Activities of Daily Living - Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

11.09 Traumatic Brain Injury

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's neurological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented disorganization of motor function that significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

OR

C. Activities of Daily Living - Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

11.10 Coma or Persistent Vegetative State

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's neurological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Activities of Daily Living - Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

11.11 Motor Neuron Disorders

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's neurological disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented disorganization of motor function that significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

OR

C. Activities of Daily Living - Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

11.12 Neurological Disorders that do not meet one of these listings – If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider should be submitted. The documentation included in the attestation must provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

12.0 Mental Disorders

Overview

DHHS's list of Medically Frail ICD-10 diagnosis codes contain a number of Mental Health disorders that qualify a beneficiary as medically frail. If the beneficiary does not meet one or more of the many diagnosis included on DHHS's list, DHHS will evaluate the beneficiary's mental health disorders as outlined in this section.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical evidence that documents the severity of the beneficiary's mental health disorder, including but not limited to: This may include Global Assessment of Functioning (GAF) score outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or other acceptable mental health assessment mechanism such as the World Health Organization Disability Assessment Schedule 2.0 (WHODAS).
2. Assessment of the beneficiary's ability to function independently in an appropriate and effective manner in the functional areas of (1) Vocational/Educational, (2) Social Skills, or (3) Activities of Daily Living.

12.01 Neurocognitive disorders

Required Documentation

A. Provider documented that disorder significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of:

   a. Vocational/Educational, or
   b. Social Skills, or
   c. Activities of Daily Living.

   This may include GAF, WHODAS or other score or other acceptable mental health assessment mechanism.

12.02 Schizophrenia spectrum and other psychotic disorders

Required Documentation

A. Provider documented that disorder significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of:

   I. Vocational/Educational

II. Social Skills, or
III. Activities of Daily Living.

This may include GAF, WHODAS or other score or other acceptable mental health assessment mechanism.

12.03 Depressive, bipolar and related disorders

Required Documentation

A. Provider documented that disorder significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of:

I. Vocational/Educational, or
II. Social Skills, or
III. Activities of Daily Living.

This may include GAF, WHODAS or other score or other acceptable mental health assessment mechanism.

12.04 Intellectual disorder

Required Documentation

A. Provider documented that disorder significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of:

I. Vocational/Educational, or
II. Social Skills, or
III. Activities of Daily Living.

This may include GAF, WHODAS or other score or other acceptable mental health assessment mechanism.

12.05 Anxiety and obsessive-compulsive disorders

Required Documentation

A. Provider documented that disorder significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of:

I. Vocational/Educational, or
II. Social Skills, or
III. Activities of Daily Living.

This may include GAF, WHODAS or other score or other acceptable mental health assessment mechanism.

12.06 Somatic symptom and related disorders

Required Documentation

A. Provider documented that disorder significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of:

I. Vocational/Educational, or
II. Social Skills, or
III. Activities of Daily Living.

This may include GAF, WHODAS or other score or other acceptable mental health assessment mechanism.

12.07 Personality and impulse-control disorders

Required Documentation

A. Provider documented that disorder significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of:

I. Vocational/Educational, or
II. Social Skills, or
III. Activities of Daily Living.

This may include GAF, WHODAS or other score or other acceptable mental health assessment mechanism.

12.08 Autism spectrum disorder

Required Documentation

A. Provider documented that disorder significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of:

I. Vocational/Educational, or
II. Social Skills, or
III. Activities of Daily Living.

This may include GAF, WHODAS or other score or other acceptable mental health assessment mechanism.

Required Documentation

A. Provider documented that disorder significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of:

   I. Vocational/Educational, or
   II. Social Skills, or
   III. Activities of Daily Living.

   This may include GAF, WHODAS or other score or other acceptable mental health assessment mechanism.

12.10 Eating disorders

Required Documentation

A. Provider documented that disorder significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of:

   I. Vocational/Educational, or
   II. Social Skills, or
   III. Activities of Daily Living.

   This may include GAF, WHODAS or other score or other acceptable mental health assessment mechanism.

12.11 Trauma- and stressor-related disorders

Required Documentation

A. Provider documented that disorder significantly interferes with the individual's ability to function independently in an appropriate and effective manner in the functional areas of:

   I. Vocational/Educational, or
   II. Social Skills, or
   III. Activities of Daily Living.

   This may include GAF, WHODAS or other score or other acceptable mental health assessment mechanism.

12.12 Mental Disorders that do not meet one of these listings – If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider should be submitted. The documentation included in the attestation must provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

13.0 Cancer Disorders (Malignant Neoplastic Diseases)

Overview

DHHS evaluates cancer disorders based on whether the beneficiary is currently in cancer treatment, has completed treatment and needs assistance in at least on activity of daily living, experiencing significant side effects from treatment that impact other body systems, or have received a transplant.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical evidence that documents the severity of the beneficiary's cancer disorder. Medical evidence may include medical history, physical examination findings, summary results of medically appropriate imaging, other relevant laboratory tests, and/or descriptions of any prescribed treatment, the beneficiary's choice to pursue treatment or decline to purse treatment, and, if applicable, the beneficiary's response to treatment.

   OR

2. The beneficiary is currently receiving radiation or chemotherapy

   OR

3. Assessment of the beneficiary's activities of daily living due to Cancer disorder including those who have completed treatment within the prior 3 months.

Category of Impairment

Each condition below will be evaluated by DHHS using the criteria noted above unless otherwise specified.

13.01 Soft Tissue Cancers of the Head and Neck

13.02 Skin

13.03 Soft Tissue Sarcoma

13.04 Lymphoma

13.05 Leukemia

13.06 Multiple Myeloma

13.07 Salivary Glands

13.08 Thyroid Gland

13.09 Breast

13.10 Skeletal System Sarcoma

13.11 Maxilla, Orbit or Temporal Fossa

13.12 Nervous System

13.13 Lungs

13.14 Pleural or Mediastinum

13.15 Esophagus or Stomach

13.16 Small Intestine

13.17 Large Intestine

13.18 Liver of Gallbladder

13.19 Pancreas

13.20 Kidneys, Adrenal Glands or Ureters Carcinoma

13.21 Urinary Bladder Carcinoma

13.22 Cancers of the female genital track, carcinoma or sarcoma

13.23 Prostate Gland

13.24 Testicles

13.25 Penis

13.26 Primary site unknown

13.27 Cancer treated by bone marrow or stem cell transplantation

13.28 Malignant Melanoma

13.29 Transplant

A. If the beneficiary received a bone marrow transplant, DHHS will consider the beneficiary Medically Frail for 3 years from the date of the transplant. Beneficiaries who receive organ transplants generally have impairments that meet DHHS's definition of Medically Frail before they undergo transplantation.

OR

B. If the beneficiary is on the United Network for Organ Sharing (UNOS) waiting list for a transplant, we will consider the beneficiary to be Medically Frail from the date the

beneficiary is added to the waiting list. The beneficiary or health care provider can supply verification that the beneficiary is on a transplant waiting list.

13.30 Cancer that do not meet one of these listings – If the beneficiary, provider, or referring party believes the beneficiary is medically frail, but cannot be identified in these criteria, an attestation signed by a qualified provider must be submitted. The documentation included in the attestation should provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section

14.0 Immune System Disorders

Overview

We evaluate immune disorders that cause dysfunction in one or more components of your immune system. We evaluate autoimmune system disorders caused by dysfunctional immune responses directed against the body's own tissues, resulting in chronic, multisystem impairments that differ in clinical manifestations, course, and outcome. They are sometimes referred to as rheumatic diseases, connective tissue disorders, or collagen vascular disorders. Immune deficiency disorders, excluding HIV infection. are characterized by recurrent or unusual infections that respond poorly to treatment and are often associated with complications affecting other parts of the body. Immune deficiency disorders can be congenital or acquired.

Documentation Required by DHHS

The following provides information to beneficiaries, their providers, and Heritage Health Managed Care Organizations (MCOs) for submitting supporting documentation to DHHS that demonstrates that the beneficiary is Medically Frail.

1. DHHS requires medical evidence that documents the severity of the beneficiary's immune disorder. Medical evidence may include medical history, physical examination findings, the results of appropriate medical imaging, constitutional symptoms and signs, persistence, and are recurrent.
2. Exacerbations specific to the disorder (*primary diagnosis*) that results in inpatient hospitalization or frequent emergency department visits.
3. Assessment of the beneficiary's activities of daily living due to the disorder.

14.01 Systemic Lupus Erythematosus

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's immune disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented organs/body system involved and constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) resulting in an extreme limitation of the ability to walk or interferes very seriously with an individual's ability to initiate, sustain, or complete activities, or Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. Activities of Daily Living Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

14.02 Systemic Vasculitis

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's immune disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented organs/body system involved and constitutional symptoms or signs (sever fatigue, fever, malaise, or involuntary weight loss) resulting in an extreme limitation of the ability to walk or interferes very seriously with an individual's ability to initiate, sustain, or complete activities, or involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively.

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. Activities of Daily Living Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

14.03 Systemic Sclerosis (Scleroderma)

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's immune disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented organs/body system involved and constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) resulting in an extreme limitation of the ability to walk or interferes very seriously with an individual's ability to initiate, sustain, or complete activities, or involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively..

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. Activities of Daily Living Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

14.04 (Polymyositis and Dermatomyositis)

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's immune disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented organs/body system involved and constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) resulting in an extreme limitation of the ability to walk or interferes very seriously with an individual's ability to initiate, sustain, or complete activities, or involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively..

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. Activities of Daily Living Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

14.05 Undifferentiated and Mixed Connective Tissue Disease

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's immune disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented organs/body system involved and constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) resulting in an extreme limitation of the ability to walk or interferes very seriously with an individual's ability to initiate, sustain, or complete activities, or involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively..

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. Activities of Daily Living Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

14.06 Immune Deficiency Disorders (Excluding HIV)

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's immune disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented organs/body system involved and constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) resulting in an extreme limitation of the ability to walk or interferes very seriously with an individual's ability to initiate, sustain, or complete activities, or involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively..

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. Activities of Daily Living Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

14.07 Inflammatory Arthritis

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's immune disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented organs/body system involved and constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) resulting in an extreme limitation of the ability to walk or interferes very seriously with an individual's ability to initiate, sustain, or complete activities, or involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively..

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. Activities of Daily Living Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

14.08 Sjögren's Syndrome

Required Documentation

A. 3 or more visits to primary care physician or specialist over the last 12-month period due to the beneficiary's immune disorder (*primary diagnosis for PCP or specialist visit*).

OR

B. Documented organs/body system involved and constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) resulting in an extreme limitation of the ability to walk or interferes very seriously with an individual's ability to initiate, sustain, or complete activities, or involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively..

OR

C. Exacerbations or complications requiring a hospitalization within the 12-month period immediately prior to the application or re-determination of the member's Medically Frail status. The hospitalization may include admission due to orders of a primary care physician or through an emergency department. The admissions must last at least 48 hours, which may include hours in a hospital emergency department immediately before the hospitalization.

OR

D. Activities of Daily Living Assessment that the beneficiary requires help to complete the task safely and helper **DOES** need to be physically present throughout the task for each occurrence.

14.09 Immune Disorders that do not meet one of these listings – If the beneficiary, provider, or referring party believes the beneficiary is Medically Frail, but cannot be identified in these criteria, an attestation signed by a qualified provider must be submitted. The documentation included in the attestation should provide evidence that the condition significantly impairs the beneficiary's ability to function or requires substantial medical oversight.

End of Section