STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 234
Hospital Transmittal No. 213
Medical Day Care Transmittal No. 78
July 1, 2011

TO: Nursing Home Administrators
Chronic Hospital Administrators
Special Pediatric Hospital Administrators
Medical Adult Day Care Center Directors

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

SUBJECT: DHMH 257 – Revised Form and Process

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The Maryland Medical Assistance Program has revised the Long Term Care Patient Activity Report (DHMH 257-Rev. 4/2011). The form has been revised to more clearly reflect the various uses of the form (e.g., Medicare co-insurance, temporary stays, etc.). Please note that when initiating payment for Medicare coinsurance, reimbursement of bed reservation days under a Medicare stay, or a temporary stay, both begin and end dates must be entered.

Please note that, for nursing facility residents already community Medicaid-eligible, initially admitted to a nursing facility on Medicare co-pay days and now applying for full payment under Medicaid long term care benefits, the DHMH 257 form should be submitted once only: to indicate the beginning and end of the Medicare co-pay period, and the date on which full Medicaid long term care benefits are requested to begin.

The revised DHMH 257 form and instructions for completion are attached for your reference. Providers may begin using the revised form effective immediately. Through July 31, 2011, the Program will accept either the earlier version or the revised version. For transactions submitted on or after August 1, 2011, however, only the revised forms will be accepted.

Please address and submit completed DHMH 257 forms as follows:

Nursing facilities and chronic hospitals:

Enter one of the following addresses under "TO: Receiving Agency":

1. Local Department of Social Services or the Bureau of Long Term Care Eligibility, unless otherwise indicated in #2 or 3 below

2. Waiver participants with an anticipated stay of less than 30 days under Medicaid or up to 80 days Medicare coinsurance - Division of Eligibility Waiver Services, 6 St. Paul Street, Suite 400, Baltimore, MD 21202

3. Non-Waiver participants with an anticipated stay of fewer than 30 days under Medicaid or up to 80 days Medicare coinsurance - LTC Processor, P.O. Box 13066, Baltimore, MD 21203

For cases where Utilization Control Agent certification of medical eligibility is required, please submit all copies to Delmarva Foundation for Medical Care, 4920 Centreville Road, Easton, MD 21601. The Agent will certify the appropriate level of care, return the "Provider" copy to the provider, retain the "UCA" copy, and forward the "Agency" copy to the appropriate agency for confirming financial eligibility, as indicated above.

If Agent certification is not required, please submit the "Agency" and "UCA" copies directly to appropriate eligibility agency, and retain the "Provider" copy.

Medical day care centers

Enter the following address under "TO: Receiving Agency": DHMH, Division of Community Long Term Care, 201 W. Preston Street, Room 133, Baltimore, MD 21201. All copies of the DHMH 257 shall be submitted to this address. Following processing, the "Provider" copy will be returned to the provider.

Nursing facilities and chronic hospitals that have questions regarding completion of the DHMH 257 should contact the Division of Long Term Care Services at 410-767-1736. Medical adult day care centers that have questions should direct them to the Division of Community Long Term Care at 410-767-1444.

Attachments

cc: Nursing Home Liaison Committee
Bureau of Long Term Care Eligibility
Local Departments of Social Services
Maryland Association of Adult Day Services

INSTRUCTIONS FOR COMPLETING THE DHMH 257 (Rev. 4/2011)

TO-Enter the name and address of the designated agency responsible for determining eligibility for benefits. For contact information or other detail, please contact the specific Program area.

FROM-Enter name, address, Medicaid Provider ID, and CARES Vendor ID. Check appropriate provider type.

RECIPIENT INFORMATION-Enter full name (first, MI, last) of recipient. Enter both Medicare and Medicaid numbers. If no Medicare, enter "none." If approval for Medicaid eligibility is pending, enter "pending."

IF RECIPIENT IS A COMMUNITY MEDICAL ASSISTANCE RECIPIENT OR WAIVER PARTICIPANT and is expected to stay in the nursing facility or chronic/special hospital for less than 30 days (or up to 80 days Medicare coinsurance), check the "Community MA" or "Waiver" box at the top right of the form.

ACTION REQUESTED-Begin Payment-Enter data fields as instructed below. Enter all dates required on that line. If the column titled "UCA" is checked below, certification by the Department's Utilization Control Agent (UCA) is required.

Nursing Facility (NF) or Chronic/Special Hospital (CSH) Activities		UCA
Initiate NF or CSH benefits, MA only	Line A1	X
Initiate NF or CSH benefits, start Medicare co-payment, convert to full MA	Lines A1 and A2 (both begin and end dates for Medicare co-insurance must be entered)	X
Initiate NF or CSH benefits, Medicare co-payment only (no full MA)	Line A2 (both begin and end dates for Medicare co-insurance must be entered)	
Initiate NF benefits, payment for bed reservations during initial full Medicare coverage	Line A3 (both begin and end dates for bed reservation payment must be entered)	X
Community MA recipient or Waiver participant for temporary NF or CSH placement less than 30 days Medicaid or up to 80 days coinsurance	Check "Community" or "Waiver" box at top right, Lines A1 and B1 (check "Community" as discharge destination).	X
Hospice recipient revoking Hospice care and returning to NF care	Line A4	X
Discharge from NF or CSH to another NF or CSH	Line B1, check "Another Provider" box, write name of receiving NF or CSH	
Discharge from NF or CSH to home, or to destination other than NF or CSH if not returning to facility	Line B1, check "Community"	
Died while in NF, CSH, or in acute hospital while on bedhold from NF	Line B2	

Medical Day Care (MDC) Center Activities	
Initiate MDC benefits	Line A1, enter Begin Pay date and check "Initial"
Continue MDC benefits	Line A1, check "Continued" and enter Begin Pay date
Discharge	Line B1, check "Discharge" box and enter date of discharge
Discharged-admitted to NF for long term care	Line B1, check "Another Provider" box, write name of nursing facility if known (otherwise enter "NF")
Died while a participant	Line B2, enter date of death

SIGNATURE-Sign and date the form. The facility staff person completing the form should print his/her name and title.

SUBMISSION -If UCA certification is required, send the Agency and UCA copies to the UCA and retain the provider copy. Otherwise, send the Agency and UCA copies directly to the designated agency and retain the provider copy.

LONG TERM CARE ACTIVITY REPORT

□ Community MA □ Waiver

For Agency Use Only
Date Received
Control No.
Due Date
Completed

TO: Receiving Agency____________________

Address ____________________

____

FROM: Name of Provider ____________________

Address____________________

____

Medicaid Provider ID____________________ CARES Vendor ID____________________

Contact Name____________________ Telephone____________________

PROVIDER TYPE □ Nursing Facility □ Chronic/Special Hospital □ Medical Day Care Center □ Other____________________

RECIPIENT INFORMATION

Name ____________________ Sex □ M □ F Date of Birth ____________________

Medicare Claim No. ____________________ MD Medicaid No. ____________________

Representative____________________ Phone____________________

Address____________________

ACTION REQUESTED - COMPLETE EITHER BOX A OR B AS APPROPRIATE, AND PRINT AND SIGN NAME/DATE

* *

A. Begin Payment Admission Date____________ Private pay rate__________

Check all that apply - both beginning and ending pay dates must be completed when requested. NOTE: Actions marked with "*" require Utilization Control Agent/DHMH certification

1. □ *Full MA coverage Begin pay date______________ For MDC only □ Initial □ Continued
2. □ Medicare A co-payment Begin pay date __________ End pay date ____________
3. □ Bed reservations for Medicare full coverage period Begin pay date____________ End pay date_____________
4. □ *Revocation of Hospice care and return to NF care Effective date____________

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B. Cancel Payment

1. □ Discharged to □ Another Provider □ Community □ Hospice Date of Discharge ______________

   If discharged to another provider, name of provider ____________________

2. □ Death – Date of Death ____________________

* *

Administrator/Designee Signature____________________ Date____________________

Print Name of Administrator/Designee____________________ Title____________________

Level of Care Certification (For UCA/DHMH Use Only)

The above named recipient is certified for the following level of care (check one):

□ Chronic/Special Hospital □ Nursing Facility Effective Dates ______________ through______________

____________________ ____________________ ____________________

Utilization Control Agent/DHMH Authorized Signature M/D/YYYY

DHMH 257 (Revised 4/2011)

AGENCY/UCA/PROVIDER COPY