

DEPARTMENT OF HEALTH AND MENTAL HYGIENE



MARYLAND MEDICAL ASSISTANCE PROGRAM

NURSING FACILITY ASSESSMENT and REIMBURSEMENT HANDBOOK

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GENERAL INFORMATION

I. INTRODUCTION

The Maryland Medical Assistance Program Nursing Facility Assessment and Reimbursement Handbook is intended to serve as a guide to nursing facilities in evaluating the appropriate Medical Assistance reimbursement for each recipient, and to the Utilization Control Agent in conducting postpayment review of nursing facility reimbursement. Vital information regarding Maryland Medicaid's nursing facility reimbursement system is provided. Specific standards for each reimbursement level are defined here, as are requirements for dependencies in each activity of daily living and reimbursement requirements for ancillary nursing services. Additionally, the Handbook provides valuable information regarding the Utilization Control Agent's role in postpayment record review (also known as patient assessment). Finally, the Handbook furnishes useful details on topics related to the patient assessment process, such as MDS 3.0 requirements and instructions on challenging adverse reimbursement determinations.

It is critical to note that the information in this Handbook is not intended as a tool in completing the MDS 3.0. The MDS 3.0 must be completed in accordance with instructions provided by the federal Centers for Medicare and Medicaid Services (CMS) through the Office of Health Care Quality. Inquiries regarding the MDS 3.0 should be directed to the Office of Health Care Quality at (410) 402-8201.

The standards set forth in this Handbook are pursuant to COMAR 10.09.10 and Nursing Home Transmittals based upon this regulation. The Handbook is issued by the Department of Health and Mental Hygiene, Office of Health Services, Medical Care Programs. Any questions regarding the information provided in this Handbook should be addressed to the Nursing Facility Program at (410) 767-1736.

II. REIMBURSEMENT LEVELS AND ANCILLARY SERVICES

Under the Maryland Medical Assistance Program's case-mix reimbursement system, the determination of reimbursement rates for nursing costs is based upon a recipient's dependency in Activities of Daily Living (ADLs), and need for and receipt of ancillary nursing services. Each recipient is assigned a reimbursement level depending on his or her degree of dependency in ADLs. The ADLs considered in establishing the reimbursement level are:

1. Mobility
2. Bathing
3. Dressing
4. Continence
5. Eating

The reimbursement levels for which the Program reimburses and the ADL criteria for each reimbursement level are:

Light (revenue code 0120)	Dependent in 0, 1 or 2 ADLs
Moderate (revenue code 0129)	Dependent in 3 or 4 ADLs
Heavy (revenue code 0190)	Dependent in all 5 ADLs
Heavy Special (revenue code 0199) Dependent in all 5 ADLs AND requires and receives one or more of: Communicable Disease Care, Central Intravenous Line, Peripheral Intravenous Care, Decubitus Ulcer Care, Tube Feeding, Ventilator Care, or Support Surface A or B during the majority of the month.	

In addition to the reimbursement level, the Program may also reimburse the facility if a recipient needs and receives one or more of the ancillary services listed below. Ancillary services are classified as Special, Additional or Therapy Services. Receipt of Special Services for the majority of the month may also qualify the facility for an enhanced Heavy Special reimbursement rate as described above.

A. Special Services	Revenue Code(s)
1. Communicable Disease Care	0239
2. Central Intravenous Care	0269
3. Peripheral Intravenous Care	02604.
4. Decubitus Ulcer Care	0550 and 0272
5. Tube Feeding	
a. Medicare	0559
b. Medicaid only	0559 and 0279
6. Ventilator Care	0419
7. Support Surface A	0290
8. Support Surface B	0299
 B. Additional Services	
1. Oxygen/Aerosol Therapy	0412
2. Suctioning/Tracheostomy Care	0410
3. Turning and Positioning	0230
4. Negative Pressure Wound Therapy	0550 and 0270
5. Bariatric Bed A	0946
6. Bariatric Bed B	0291
 C. Therapy Services	
1. Physical Therapy	0420
2. Occupational Therapy	0430
3. Speech Therapy	0440

Reimbursement is available when the requirements as delineated in this Handbook are met, and the recipient is present in the facility on the day in question. On those days when the recipient is hospitalized or on a leave of absence, a reduced payment will be made. The categories under which the reduced payment is made are:

1. Hospital leave - up to 15 days per spell of illness
2. Leave of absence - up to 18 days per calendar year

The specific requirements for each activity of daily living, hospital and home leave, administrative days, and ancillary service are detailed beginning on page 7 of this Handbook.

III. RESIDENT ASSESSMENT SYSTEM

Recipients' dependency and reimbursement levels are assessed based upon certain required data elements in the instrument known as the Minimum Data Set Version 3.0, or MDS 3.0. The entire MDS 3.0 must be completed upon admission and at least annually thereafter. Additionally, the entire MDS instrument must be completed when there is a significant change in the recipient's condition. Selected data must be provided quarterly on the MDS Quarterly Assessment Form and monthly on the Maryland Monthly Assessment.

To enable the Agent to perform a complete, accurate assessment, facilities are required to complete the Maryland Monthly Assessment each month. The monthly assessment must be completed no later than 31 days following the prior assessment update. Failure to complete the Maryland Monthly Assessment timely may result in the facility losing reimbursement for the month in question. The items that correspond to selected MDS 3.0 items must be completed in accordance with MDS 3.0 instructions. Information on the recipient's functioning during the period requested in the MDS 3.0 (7-14 days) will be considered to reflect the recipient's functioning during the majority of the month, the current month for assessments completed the first half of the month and the following month for assessments completed in the latter half. The following MDS 3.0 sections, as well as the corresponding Maryland Monthly Assessment sections, are used primarily to verify reimbursement levels or receipt of ancillary services. Please note that the term MDS 3.0 as used in Key Documentation sections may refer to either the annual MDS 3.0, the Quarterly Assessment, or the Maryland Monthly Assessment. The sections are as follows:

- G. Functional Status
- H. Bladder and Bowel
- K. Swallowing/Nutritional Status
- M. Skin Conditions

In those instances where supplementary documentation is required to justify reimbursement, it may be entered on the back of the Maryland Monthly Assessment form or in the progress notes on a monthly basis. In the absence of such documentation the recipient may not be considered as requiring supervision or assistance consistent with a level of dependency to justify Program reimbursement. This Handbook identifies key sources of documentation, however, the entire medical record will be used to determine a recipient's reimbursement level and need for and receipt of ancillary services, based on the definitions provided in this Handbook.

IV. REVIEW PROCESS

Verification of appropriateness of reimbursement is accomplished through postpayment review of each recipient's medical records. On a monthly basis, the facility invoices, and the Program pays, based on the facility's assessment of each recipient's reimbursement level and need for and receipt of ancillary services. Once each quarter, the Program's Utilization Control Agent (hereafter known as the Agent) visits the facility onsite to conduct a postpayment review of Program payments against the recipient's medical records. The purpose of this postpayment review, which is known as patient assessment, is to ascertain whether the documentation found in the recipient's medical record supports the Program's reimbursement. The results of this assessment are entered into the Medicaid Management Information System (MMIS-II) and compared with each facility's paid claims. Payment adjustments are then made, based on the assessment findings. MMIS-II produces computerized reports detailing the assessment findings and adjustments. These reports are furnished to the facility.

V. FACILITY RESPONSIBILITY

It is the nursing facility's responsibility to assure that the appropriate personnel maintain contemporaneous records of the recipient's condition, including but not limited to the Resident Assessment Instrument, MDS 3.0, the MDS Quarterly Assessment form, the Maryland Monthly Assessment, plan of care, medication sheets, treatment sheets and physician orders and progress notes. The medical record must contain progress notes every 30 days by the attending physician in accordance with COMAR 10.07.02.10D, documenting periodic review of the recipient's status and the recipient's treatment plan, unless an alternative schedule for physician visits is employed in accordance with COMAR 10.07.02.10E. When an alternative schedule is employed the minimally acceptable interval for physician documentation is 60 days. It is recommended that all documentation be accessible in the recipient's record for a minimum of six months, longer if the facility is billing for the recipient for the first time. Reimbursement will not be allowed for services that have not been adequately documented as necessary and provided. Clear, concise, descriptive documentation, actually reflecting the recipient's condition, is required.

The facility is also responsible for providing the Agent easy access to the medical records. Any documentation removed from the record must be readily available, as the Agent will not be required to make excessive efforts to obtain documentation.

If it is obvious to the Agent that the documentation and/or the services provided were solely for the purpose of reimbursement, the facility will not be reimbursed. Additionally, in all instances where the Agent has cause to question whether the services were actually provided, or whether the documentation and/or the services provided were solely for the purpose of reimbursement, a referral will be made to the Office of Health Services. A preliminary review will be conducted to determine if the facility should be referred to the Department's Office of the Inspector General or the Attorney General's Medicaid Fraud Control Unit (MFCU) for investigation.

ACTIVITIES OF DAILY LIVING

I. MOBILITY

Item Definition: The recipient's current ability to move with or without the customary use of mechanical aids when moving from bed to chair or wheelchair, and from bed or chair to a standing position.

Not Included: Efforts required to apply a brace or prosthesis are included in dressing.

A. Independent:

1. The recipient does not require assistance in transferring, walking and/or wheeling;
2. The recipient uses assistive devices such as crutches, walker, or wheelchair without the personal assistance of staff, even if the assistive device is brought by staff to the recipient.

B. Dependent:

1. The recipient is able to ambulate with or without mechanical assistance or assistive devices (including electric wheelchair) but requires hands on physical assistance getting in or out of bed or chair;
2. The recipient is unable to ambulate without staff assistance or supervision, is wheeled, or is bed/chair confined;
3. The recipient cannot participate significantly in the process of walking/wheeling or transferring, but is able to reposition self in bed or in chair; or
4. The recipient is bed/chair confined - A BED/CHAIR CONFINED recipient:
 - a. Cannot reposition self to prevent skin breakdown;
 - b. Is completely dependent on staff to move from bed to chair or chair to bed; and
 - c. Requires a daily maintenance schedule for repositioning and turning by nursing staff.

KEY DOCUMENTATION - Coding indicative of dependency in Mobility is identified as follows.

	<u>Self Performance</u>	<u>Support</u>
Dependent:		
MDS 3.0 - Section G - Functional Status		
G0110.B Transfer	2, 3 or 4	2 or 3
Bed Chair confined:		
MDS 3.0 - Section G - Functional Status		
G0110.A Bed Mobility	4	2 or 3
G0110.B Transfer	4	2 or 3
G0110.C Walk in Room	8	8
G0110.D Walk in Corridor	8	8
G0110.E Locomotion on Unit	0-3 ¹ , 4 or 8	2, 3 or 8
G0110.F Locomotion Off Unit	0-3 ¹ , 4 or 8	2, 3 or 8
G0600 Mobility Devices		C2

¹If the recipient uses a motorized wheelchair, coding under "Locomotion on/off unit", may be "0, 1, 2, or 3". Use of motorized wheelchair must be documented.

² Use of motorized wheelchair must be documented.

II. BATHING

Item Definition: The description which best typifies the recipient's overall performance of bathing or showering activities in a given month.

A. Independent:

1. No staff assistance is required in any part of the process of taking a sponge bath, shower or tub bath to wash the whole body;
2. The recipient washes herself, but requires staff supervision for safety reasons;
3. The recipient is able to wash all but one extremity; or
4. The recipient uses only mechanical aides to assist in the bathing process, such as shower/tub chair, grab-rails, pedal/knee controlled faucets, or long handle brush.

B. Dependent:

1. The recipient receives assistance, beyond that described in A above, in washing himself;
2. Water is brought to the recipient, even though she washes herself;
3. The recipient was helped in or out of tub, shower or bathing chair as regularly as once a week; or
4. The recipient is completely bathed by staff and does not participate in his own bath.

KEY DOCUMENTATION - Coding indicative of dependency in Bathing is identified as follows.

	<u>Self Performance</u>	<u>Support</u>
MDS 3.0 - Section G - Functional Status		
G0120 Bathing	2, 3 or 4	2 or 3

III. DRESSING

Item Definition: The process of putting on, fastening and taking off all items of clothing, braces, or artificial limbs that are worn daily by the recipient including obtaining and replacing the items from their storage area in the immediate environment.

Clothing refers to the clothing usually worn daily by the recipient. Recipients who wear pajamas or gown with robe and slippers as their usual attire are considered dressed.

NOTE: Hand mitts, elbow pads, heel pads and knee pads are included as part of the dressing function.

A. Independent:

1. The recipient does not receive staff assistance or supervision in obtaining clothes from closets and drawers, putting on the clothes, including brace (if usually worn), outer garment, and footwear;

2. Fasteners (buttons, zippers etc.) are managed without staff assistance. If a recipient receives help in tying shoes only she is considered independent;

3. The recipient only uses mechanical help to complete the dressing process such as long handled shoehorns, zipper pulls, Velcro fasteners, or walker with attached basket used to obtain clothing.

B. Dependent:

1. The recipient usually receives assistance from staff in obtaining clothes, fastening hooks, or putting on clothes, braces, or artificial limbs;

2. The recipient requires supervision or instruction in order to dress himself;

3. The recipient receives the assistance of staff and also uses the aide of mechanical devices; or

4. The recipient is completely dressed by staff.

KEY DOCUMENTATION - Coding indicative of dependency in Dressing is identified as follows.

MDS 3.0 - Section G - Functional Status

	<u>Self Performance</u>	<u>Support</u>
G0110.G Dressing	1 ¹ , 2, 3, 4 or 8 ²	2 or 3

¹ When Self Performance Code is a 1, then the exact assistance or supervision must be documented to assure accurate recipient assessment.

²A Self Performance code of 8 may be used when a recipient wears pajamas or gown with robe and slippers as the usual attire; documentation of this must be provided to assure accurate assessment.

IV. CONTINENCE

Item Definition: The physiological process of voluntary elimination from the bowels and/or bladder. Incontinence is the involuntary loss of control. This item only refers to the function of control and does not include hygiene, toileting, adjusting clothes, or other staff assistance addressed under Bathing, Dressing or Mobility.

A. Independent:

1. The recipient is continent of bowel and bladder;
2. The recipient is able to completely care for own ostomy;
3. Accidents occur only 1 or 2 times per week;
4. The recipient is able to tell staff of need regardless of mobility status.

B. Dependent:

1. Accidents occur three or more times per week;
2. Daily incontinence care is needed because of inability to control bladder or bowels;
3. The recipient is unable to notify staff in advance of need;
4. Continence is maintained through regularly scheduled and documented staff assistance in advance of need;
5. Indwelling, suprapubic or Texas catheter is utilized; or
6. The recipient is unable to completely care for own ostomy.

KEY DOCUMENTATION - Coding indicative of dependency in Continence is identified as follows.

	<u>Self Performance</u>	<u>Support</u>
MDS 3.0 - Section G		
G0110.I ¹	2, 3 or 4	2 or 3
MDS 3.0 - Section H - Bladder and Bowel		
H0100	Appliances	checked A, B, C, or D
H0200.C	Current toileting program or trial	1
H0300	Urinary Continence	0 ² , 1 ³ 2, 3 or 9
H0400	Bowel Continence	0 ⁴ 2, 3 or 9
H0500	Bowel Toileting Program	1

¹Applies only to recipient's ability to care for ostomy.

²If a "0" code is used, items A, B, C, or D must be checked under H0100.

³If "1" is used, the exact number of incontinent episodes must be documented.

⁴If a "0" code is used, item C under H0100 must be checked.

V. EATING

Item Definition: The process of getting food by any means from the plate (receptacle) into the body. This item describes the process of eating AFTER the fully prepared, ready-to-eat food has been placed in front of the recipient. This standard includes nasogastric tube feeding or gastrostomy feedings, but excludes the recipient being maintained solely by IV or being taught self-care of gastrostomy.

A. Independent:

1. The recipient is able to feed self when given a fully prepared ready-to-eat meal; or
2. Assistance of staff is required for tray set-up and preparation including cutting meat, buttering bread, opening containers, and pouring milk; BUT the recipient is successful in getting the food from the plate into her body by herself.

B. Dependent:

1. Staff assistance is required while eating in order to achieve adequate nutrition on a daily basis;
2. A staff member must remain with the recipient during all feedings to guard against life threatening incidents (choking);
3. The recipient is Spoon fed: A recipient is classified as dependent when:
 - a. Routinely fed by a staff member because the recipient is unable to bring food to his mouth;
 - b. Occasionally the recipient may feed himself, but not on a "majority of the month" basis; or
4. The recipient is fed by nasogastric or gastrostomy tubes:
 - a. This recipient is fed a prescribed diet via naso-oral gavage tube or gastro-gavage tube; and
 - b. This activity includes insertion of the tube, care of the gastric opening, and feeding through the tube with accurate documentation of the diet and feedings.

KEY DOCUMENTATION - Coding indicative of dependency in Eating is identified as follows.

	<u>Self Performance</u>	<u>Support</u>
MDS 3.0 – Section G - Functional Status		
G0110.H	Eating Eating 1 ¹ ,2, 3 or 4	2 or 3
MDS 3.0 - Section K - Swallowing/Nutritional Status		
K0100.C	Coughing or choking during meals...	checked
K0500.A	Parenteral/IV feeding	checked
K0500.B	Feeding tube	checked
K0700.A	Proportion of total calories...	3

¹When Self Performance Code is a 1, then the exact assistance or supervision required to achieve adequate nutrition on a daily basis must be documented to assure accurate recipient assessment.

OTHER REIMBURSEMENT CATEGORIES

I. HOSPITAL LEAVE (0185)

Item Definition: A day on which a recipient is hospitalized for an acute condition.

NOTE:

1. Reimbursement is allowed for up to 15 days per spell of illness.
2. For a provider to be reimbursed for hospital leave, the following conditions must be met:

- a. The recipient must be admitted to the hospital for an acute condition. An acute condition is a condition for which a recipient is admitted to an acute general or special psychiatric hospital. A recipient hospitalized in a chronic, rehabilitation or other hospital facility is not considered admitted for an acute condition, consequently the provider is not eligible for this payment;
- b. The hospital leave must be reasonably expected to be 15 days or less;
- c. The provider must readmit the recipient at any time the recipient is ready for discharge from the hospital within 16 days of admission. If the provider fails to readmit the recipient upon being ready for discharge from the hospital, or delays readmission, reimbursement for the entire hospital leave period may be disallowed.
- d. Documentation of the hospitalization, including the date hospitalized, reason for hospitalization, name of hospital, date returned from the hospital or discharged from the facility, and physician's order for the hospitalization, must be present in the medical record.

3. Hospital leave begins the day the recipient enters the hospital. The date the recipient returns to the facility or is discharged to another placement is not counted as a day of hospital leave. If the recipient dies while in the hospital, that day is considered a day of hospital leave.

KEY DOCUMENTATION

1. Physician's order for acute hospitalization. The order must be specific as to admitting hospital, date and purpose for admission.
2. Medical record documentation of date of hospitalization, reason for hospitalization, name of hospital, and date of return or discharge from the facility.

II. LEAVE OF ABSENCE (0183)

Item Definition: A day on which a recipient is on a home visit extending beyond the midnight bed census or participating in a State-approved inpatient therapeutic or rehabilitative program.

NOTE:

1. Reimbursement is allowed for up to 18 days per calendar year.
2. For a provider to be reimbursed for a leave of absence, the recipient's plan of care must provide for the absence.
3. The medical record must contain documentation of the date leave began and the date the recipient returned to the facility or was discharged from the facility.
4. If a recipient leaves the facility on a home visit and does not return as of the midnight bed census, that day is considered a leave of absence day, even though the recipient does not remain out overnight.

KEY DOCUMENTATION

1. Physician order. When the leave is for participating in a therapeutic or rehabilitative program, the order must be specific as to the admitting hospital, date and reason for admission. For home visits, a general order permitting visits with family or friends is acceptable.
2. Documentation of the dates of absence.

III. ADMINISTRATIVE DAYS (0169)

Item Definition: A day of care rendered to a recipient who no longer requires the level of care provided (i.e., nursing facility level of care)

Note:

1. Only Medicaid recipients of nursing facility services whose condition changes such that they no longer need nursing facility level of care are eligible for Administrative Days. One does not qualify for Administrative Days without first having received Medicaid-covered nursing facility services.
2. There is no limit on the number of Administrative Days that a facility can be reimbursed provided:
 - a. the facility fulfills its obligation under COMAR 10.09.10.16E, and
 - b. the recipient accepts discharge to an appropriate facility as defined in COMAR 10.09.10.01B
3. The provider must detail and document its discharge planning efforts on form DHMH 2129 and retain it in the recipient's medical record. Failure to initiate or document discharge planning pursuant to COMAR 10.09.10.16E will result in denial of facility reimbursement for Administrative Days. In such a circumstance, the beneficiary can not be billed for this service (COMAR 10.09.10.03N).
4. Program reimbursement for Administrative Days may also be denied if a recipient refuses discharges to an appropriate facility as defined in COMAR 10.09.10.01B. In such an instance the facility may seek reimbursement for the day(s) of service from the recipient.

KEY DOCUMENTATION

1. Report of Administrative Days in Long Term Care Facilities (DHMH 2129).
2. Physician's certification when appropriate pursuant to COMAR 10.09.10.16.

SPECIAL SERVICES

I. COMMUNICABLE DISEASE CARE (0239)

Item Definition: Specialized care given to a recipient who has a disease which is transmitted primarily by blood/blood products and/or body fluids.

NOTE:

- A. This service does not include care provided for diseases transmitted primarily through routes other than blood/blood products and/or body fluids.
- B. It is expected that Universal Blood and Body Fluid Precautions, as defined by the Centers for Disease Control and Prevention, will be maintained for all recipients. However, these precautions in and of themselves shall not constitute grounds for reimbursement for this service.
- C. This specialized care may include, but is not limited to, medication administration and monitoring and treatment of opportunistic infections and diseases.
- D. Progress notes must reflect individualized treatments that are being provided for each Communicable Disease Care recipient.
- E. The Plan of Care must be consistent with the psychosocial status as documented in the MDS 3.0.

KEY DOCUMENTATION

- 1. Medical diagnosis indicating a communicable disease transmitted primarily by blood/blood products and/or body fluids.
- 2. Physician's Orders for individualized treatments.
- 3. Progress Notes for change in condition or special procedures.
- 4. Physician's Plan of Care must contain a diagnosis consistent with the definition of Communicable Disease.
- 5. Treatment Sheets for individualized treatments.

II. CENTRAL INTRAVENOUS LINE (0269)

Item Definition: Any day or part of a day in which an intravenous infusion is administered via an indwelling catheter into the Superior Vena Cava, or care given to maintain the patency of the line on days when infusions are not administered, e.g., Heparin flush.

NOTE:

1. This care must be ordered by a physician with frequent evaluation, as appropriate for the care needs of the recipient.
2. Must be administered and monitored on a 24-hour basis by a registered nurse, in compliance with Office of Health Care Quality requirements. All staff associated with the care of the recipient must be adequately trained and/or inserviced in areas of concern associated with Central Intravenous Care, for example, protocol for temperature elevation.
3. Appropriate dressing changes are included in reimbursement for this service.

KEY DOCUMENTATION

1. Physician's Orders.
2. 24-hour Intake/output record, if ordered by physician or otherwise appropriate.
3. Treatment Sheets, documenting appropriate dressing changes at site of insertion. Treatment Sheets and/or Medication Sheet must indicate performance and be signed off by the licensed medical professional performing the procedure.
4. MDS 2.0 Section K - Oral Nutritional Status. Item 5a Parenteral/IV checked.

III. PERIPHERAL INTRAVENOUS CARE (0260)

Item Definition: Any part of a day or a full day in which a recipient receives parenteral solutions via subcutaneous/peripheral intravenous route with or without medication, or care given to maintain the patency of the line on days when infusions are not administered, e.g., Heparin flush.

NOTE:

1. This care must be ordered by a physician with frequent evaluation.
2. Care must be administered under the supervision of a registered nurse who is available on a 24 hour basis in compliance with Office of Health Care Quality requirements.
3. The medical record must reflect the recipient's condition and orders for this service.

KEY DOCUMENTATION

1. Treatment Sheets and/or Medication Sheets must indicate performance and be signed off by the licensed medical professional providing the care.
2. Physician's Orders.

IV. DECUBITUS ULCER CARE Medicare 0550; Medicaid-only 0550 and 0272

Item Definition: The days of care given to the recipient with a Stage III or IV Decubitus Ulcer, Stasis Ulcer or similar condition. A similar condition is defined as a break, equivalent to the degree of tissue involved in a Stage III or IV ulcer, resulting from an intrinsic, rather than a traumatic factor. Note: Each reimbursable day of care is a composite of revenue code 0550, skilled nursing - general and revenue code 0272, medical/surgical supplies - sterile. For recipients with Medicare Part B, the Program pays for revenue code 0550/skilled nursing – general only. Conditions which may be reimbursed include, but are not limited to wound dehiscence, fistulas, progressive cancers and stump ulcerations. Traumatic injuries, such as lacerations or burns, are excluded. In all cases, the recipient's medical record must clearly reflect the contributing factors leading to the development of the skin break, treatment(s) provided, and progress or lack of progress of the condition.

To be reimbursed, the decubitus condition must be present upon the recipient's admission to the facility or be determined by the Department or its Agent not to be the result of inadequate or inappropriate care by the facility. When a decubitus ulcer develops even with preventative treatment measures, the facility will be reimbursed if it provides sufficient documentation showing that such development was inevitable. The medical record must clearly reflect the contributing factors leading to the development of the skin break and treatment(s) provided, and progress or lack of progress of the condition. The medical record must also contain progress notes by the attending physician documenting periodic review of the recipient's status, and of the recipient's treatment plan consistent with the severity of the recipient's condition.

Classification:

- A. Stage I - Demarcated, reddened area of the skin characterized by unbroken skin surface which feels warm, blanches to the touch and does not fade within thirty minutes after pressure has been removed.
- B. Stage II - Reddened area with a skin break involving a partial thickness ulceration of the epidermis and a portion of the dermis with superficial circulatory and tissue damage.

There is removal of an area of skin. Drainage is usually serous in nature. There may be formation of a closed blister which contains serous fluid.

C. Stage III - Full thickness loss of skin which may or may not include the subcutaneous tissue level, produces serosanguinous drainage and is surrounded by inflamed skin.

D. Stage IV - Full thickness loss of skin with invasion of deeper tissue such as fascia, muscle, tendon or bone, this consists of a deep, broken area with necrosis and white or gray or yellow soft tissue (slough). Drainage is usually purulent and foul-smelling secondary to infection. The surrounding area may be inflamed and warm to touch. This stage may also include undermining and sinus tracts also known as tunneling.

E. Unstageable – A known or suspected deep tissue injury but unstageable due to eschar or slough covering the area.

The facility will be reimbursed for the number of days that documented decubitus ulcer care was administered each month. Care is treatment ordered by a physician. more than once daily unless otherwise recommended by the manufacturer. Treatment is any specific procedure used for the cure or improvement of a condition or disease. Treatment methods for debridement of Stage III-IV decubitus ulcers may be classified as follows:

1. Mechanical
 - a. Surgical debridement
 - b. Wet-to-dry dressings
2. Chemical - enzymatic agents
3. Autolytic - occlusive or semi-occlusive film dressings, e.g., "Op-site." If "Op-site" or similar treatment has been ordered by the physician, the facility will be reimbursed for the day the treatment was actually applied or reapplied, although frequent observation is necessary.

Additional treatment modes for decubitus ulcers may include but are not limited to:

4. Irrigations
5. Heat lamp
6. Oxygen

KEY DOCUMENTATION

1. Skin Sheets. Weekly documentation by a licensed nurse. Documentation must be specific to the number of stage III and stage IV ulcers including the size (length, width and depth recorded in centimeters) ,color, eschar, sloughing and any drainage of the ulcer. The documentation should also include prescribed treatment and the recipient's response to treatment.

2. MDS 3.0 Section M - Skin Conditions

	<u>Code</u>
M0300.C.1 Current Stage III Ulcers	document current #
M0300.C.2 Stage III Ulcers at Admission	document # at admission or re-entry
M0300.D.1 Current Stage IV Ulcers	document current #
M0300.D.2 Stage IV Ulcers at Admission	document # at admission or re-entry

3. Physicians' orders and progress notes must include the wound status and treatment plan that is consistent with the severity of the wound and the recipient's response to the treatment plan.

4. Treatment Sheets and/or Medication Sheets must indicate performance and be signed off by the licensed medical professional performing the procedure.

V. TUBE FEEDING (Medicare 0559; Medicaid-only 0559 and 0279)

Item Definition: The use of naso-gastric or gastric tube as the primary method of feeding.

NOTE:

1. Includes insertion of tube, care of the opening and feeding through the tube;
2. Must be ordered by a physician; and
3. Must be administered by a licensed nurse and documented on appropriate records.

KEY DOCUMENTATION

1. MDS 3.0 - Section K - Swallowing/Nutritional Status

K0500.B	Feeding tube	checked
K0700.A	Proportion of total calories...	3
2. Physician's Orders
3. Treatment and/or Medication Sheets must indicate performance and be signed by the licensed medical professional providing the care.

VI. VENTILATOR CARE (0419)

Item Definition: Any day or part of day in which a recipient receives artificial ventilation of the lungs by mechanical means through a ventilator.

NOTE:

1. Includes Oxygen/Aerosol therapy and Suctioning/Tracheostomy care. Separate reimbursement will not be allowed for these ancillary services on the same day on which ventilator care was provided.
2. Care must be rendered in a facility authorized by the Office of Health Care Quality to provide Ventilator Care. Care must be rendered in accordance with applicable federal and State regulations.

KEY DOCUMENTATION

1. Physician's Orders.
2. Flow Sheet or Treatment and/or Medication Sheets documenting care of the ventilator care recipients, in accordance with physician order.
3. Treatment Sheet indicating O₂/Aerosol therapy and Suctioning/Tracheostomy care as applicable.
4. Other supporting documentation as necessary.

VII. SUPPORT SURFACE A (0290)

Item Definition: The days of care for which the recipient requires the use of and is placed on a Class A Support Surface. A Class A Support Surface is a mattress replacement which has been approved as a Group 2 Pressure Reducing Support Surface by the Medical Policy of the Medicare Durable Medical Equipment Regional Carriers (DMERC's). Specifically, mattresses classified under HCPCS codes E0277, E0373, E1399 and the RIK fluid mattress are covered. Additionally, the surface must have an inflated cell depth of at least five inches.

NOTE: In order to be reimbursable under this service, all of the following requirements must be met:

A. The recipient's decubitus ulcer must meet one of the following criteria (for purposes of reimbursement, staging definitions are consistent with the definitions presented in this Handbook under Decubitus Ulcer Care).

1. Recipient has multiple Stage II ulcers on trunk and no surface area of the body that is sufficiently free of ulcers and can support the body's weight to permit safe turning and positioning;

2. Recipient has one Stage III ulcer on trunk and is limited to one or no surface area of the body that is sufficiently free of ulcers and can support the body's weight to permit safe turning and positioning; or

3. Recipient has a condition which would classify him as appropriate for Class B Support Surface in accordance with the requirements set forth in this Handbook, yet the physician has determined that a Class A Support Surface would appropriately meet the recipient's needs.

B. The decubitus condition must be present upon the recipient's admission to the facility or determined by the Department or its Agent not to be the result of inadequate or inappropriate care by the facility. For decubitus ulcers which developed in the facility, there must be sufficient documentation that such development was inevitable. The medical record must contain progress notes by the attending physician documenting periodic review of the recipient's status, and of the recipient's treatment plan consistent

with the severity of the recipient's condition.

C. The support surface must be ordered by a physician and meet the above definition for Support Surface A.

D. The medical record must document that specific decubitus ulcer treatments are being provided according to the physician's orders.

E. The recipient's care plan and supporting documentation must substantiate that the facility is providing overall health care services designed to aid in the healing of the ulcers as well as to prevent the recurrence of ulcers.

Key Documentation

1. Physician's Orders.

2. Description of the support surface in use.

3. Treatment Sheets and/or Medication Sheets must indicate performance of any ordered ulcer treatments and be signed off by the licensed medical professional providing the care.

4. Skin Sheets - weekly documentation by a licensed nurse. Documentation must be specific to size (circumference and depth, in inches or centimeters), color and any drainage of the ulcer. The documentation should also include prescribed treatment and the recipient's response to treatment.

5. Documentation of management of the recipient's overall health condition, including but not limited to:

a. Nutritional assessment by registered dietician with regular updates; and

b. Laboratory tests to include serum protein and/or serum albumin, hemoglobin and hematocrit.

VIII. SUPPORT SURFACE B (0299)

Item Definition: The days of care for which the recipient requires the use of and is placed on a Class B Support Surface. A Class B Support Surface is an air fluidized bed which has been approved as a Group 3 Pressure Reducing Support Surface by the Medical Policy of the Medicare Durable Equipment Regional Carriers (DMERC's), and is classified under HCPCS code E0194.

NOTE: In order to be reimbursable under this service, all of the following requirements must be met:

A. The recipient's decubitus ulcer must meet one of the following criteria (for purpose of reimbursement, staging definitions are consistent with the definitions presented in this Handbook under Decubitus Ulcer Care).

1. Recipient has multiple Stage III ulcers and/or one or more Stage IV ulcers on trunk and is limited to one or no surface area of the body that is sufficiently free of ulcers and can support the body's weight to permit safe turning and positioning of recipient; or
2. Recipient is in the initial 60 days of post-operative recovery from myocutaneous flap or graft surgery for a decubitus ulcer on the trunk.

B. The decubitus condition must be present upon the recipient's admission to the facility or determined by the Department or its Agent not to be the result of inadequate or inappropriate care by the facility. For decubitus ulcers which developed in the facility, there must be sufficient documentation that such development was inevitable. The medical record must contain progress notes by the attending physician documenting periodic review of the recipient's status, and of the recipient's treatment plan consistent with the severity of the recipient's condition.

C. The support surface must be ordered by a physician and meet the above definition for Support Surface B.

D. The medical record must document that any specific decubitus ulcer treatments are being provided according to the physician's orders.

E. The recipient's care plan and supporting documentation must substantiate that the facility is providing overall health care services designed to aid the healing of the ulcers as

well as to prevent the recurrence of ulcers.

Key Documentation

1. Physician's Orders.
2. Description of the support surface in use.
3. Treatment Sheets and/or Medication Sheets must indicate performance of any ordered ulcer treatments and be signed off by the licensed medical professional providing the care.
4. Skin Sheets - weekly documentation by a licensed nurse. Documentation must be specific to size (circumference and depth, in inches or centimeters), color, and any drainage of the ulcer. The documentation should also include prescribed treatment and the recipient's response to treatment.
5. Documentation of management of the recipient's overall health condition, including but not limited to:
 - a. Nutritional assessment by registered dietician with regular updates; and
 - b. Laboratory tests to include serum protein and/or serum albumin, hemoglobin and hematocrit.

ADDITIONAL SERVICES

I. OXYGEN/AEROSOL THERAPY (0412)

Item Definition: The number of days oxygen was administered to a recipient. The number of days Aerosol Therapy respiratory care was administered to a recipient.

NOTE:

1. This care must be ordered by a physician.
2. Care must be administered by a licensed nurse or a registered respiratory therapist.
3. This does not include:
 - a. Recipient who administers own oxygen nebulizers, vaporizers or atomizers; or
 - b. One time Stat emergency administration of oxygen.
4. For ventilator care recipients, payment for oxygen/aerosol therapy is included in the ventilator care rate. Separate reimbursement will not be allowed for oxygen/aerosol therapy on the same day on which ventilator care was provided.

KEY DOCUMENTATION

1. Treatment and/or Medication Sheets must document the provision of care and be signed by licensed medical personnel for each shift in which the care was provided.
2. Physician's Orders.

II. SUCTION/TRACHEOSTOMY CARE (0410)

Item Definition: Any part of or a full day that a recipient receives suctioning and/or tracheostomy care, to maintain the recipient's airway.

NOTE:

1. The care must be ordered by a physician.
2. Care must be performed by a licensed nurse.
3. This includes cleaning of inner and outer cannula if appropriate and sterilization of needed equipment.
4. The suctioning equipment must be located in the recipient's room.
5. This does not include a one time Stat emergency use of suction.
6. For ventilator care recipients, payment for suction/tracheostomy care is included in the ventilator care rate. Separate reimbursement will not be allowed for suction/tracheostomy care on the same day on which ventilator care was provided.

KEY DOCUMENTATION

1. Treatment and/or Medication Sheets must document the provision of the care and be signed off by licensed medical personnel for each shift in which the care was provided.
2. Physician's Orders.

III. TURNING AND POSITIONING (0230)

Item Definition: The number of days for which a bed/chair confined recipient (as defined in the section of this Handbook that addresses Mobility) requires 24 hours turning and positioning. This includes the recipient who can sit in a chair for a portion of the day, but cannot reposition self.

NOTE:

1. A physician order is not required.
2. Recipients shall be placed on a two hour turning and positioning schedule, and turned and repositioned every two hours in accordance with this schedule.
3. A licensed nurse must document each shift that the recipient has been turned and repositioned by the appropriate personnel as scheduled.

KEY DOCUMENTATION

1. If a recipient is turned and positioned, the MDS 3.0 Section G Functional Status should indicate the recipient is bed/chair confined. A bed/chair confined recipient is defined under "Mobility" pages 7-8.
2. Treatment Sheets and/or Medication Sheets must indicate performance for all shifts and be signed by a licensed medical professional.

IV. NEGATIVE PRESSURE WOUND THERAPY 0550 and 0270

Item Definition: The days of care in which negative pressure wound therapy (NPWT) is applied to recipient with one or more of the following conditions:

- A. Stage III or IV Pressure Ulcers
- B. Neuropathic (Diabetic Ulcers)
- C. Venous Insufficiency Ulcers
- D. Surgically Created (Dehiscence)
- E. Enteric Traumatic Wound Flap/Graft only
- F. Fistulae

To be reimbursed for NPWT the wound condition must be present upon the recipient's admission to the facility or be determined by the Department or its Agent not to be the result of inadequate or inappropriate care by the facility. When a wound develops even with preventative treatment measures, the facility will be reimbursed if it provides sufficient documentation showing that such development was inevitable. The medical record must contain progress notes by the attending physician documenting periodic review of the recipient's status, and of the recipient's treatment plan consistent with the severity of the recipient's condition.

In addition to documentation noted above, the physician must document that NPWT is indicated because either:

1. Traditional treatment modalities, such as those listed under Decubitus Ulcer Care were insufficiently effective to heal the wound; or
2. Because of the recipient's medical condition or the nature of the wound, traditional treatments are likely to be ineffective or contraindicated.

Note: Each reimbursable day of care will be a composite of revenue code 0550, skilled nursing, and revenue code 0270 for the NPWT pump rental, dressings and canisters.

KEY DOCUMENTATION

1. Skin Sheets

Weekly documentation by a licensed health care provider as listed above. Documentation must be specific to size (length, width, depth, tunnels and undermining in inches or centimeters) color, and any drainage of the ulcer. The documentation should also include prescribed treatment and the recipient's response to treatment.

2. MDS 3.0 Section M - Skin Conditions

	<u>Code</u>
M0300.C.1 Current Stage III Ulcers	document current #
M0300.C.2 Stage III Ulcers at Admission	document # at admission or re-entry
M0300.D.1 Current Stage IV Ulcers	document current #
M0300.D.2 Stage IV Ulcers at Admission	document # at admission or re-entry

3. Physician's Orders.

4. Treatment Sheets and/or Medication Sheets must indicate performance and be signed off by the licensed medical professional performing the procedure.

5. Coverage will continue as long as documentation exists in the patient's chart that shows wound progress as measured by decrease in wound dimension of length, width, depth, tunnels or undermining. Or if no measurable decrease in wound dimensions, there exists documentation of changes being made to the care plan to promote healing which addresses: proper treatment of infection, debridement of devitalized tissue, pressure redistribution over the wounded area, appropriate management of moisture and incontinence; proper nutrition, and adequate perfusion to promote wound healing.

Additional Coverage Requirement

NPWT will only be covered for therapy systems that can demonstrate that it meets the following:

- Delivers controlled, regulated negative pressure to the wound using a software controlled therapy unit which allows application of continuous or intermittent

negative pressure settings ranging from 50 mmHg to 200 mmHg. The therapy unit must be able to measure and report back to the user the amount of negative pressure being received at the wound site to ensure prescribed amounts of pressure is being received to the wound bed.

- The dressing material used with the NPWT system is of a resilient, reticulated open cell design to allow for even distribution of negative pressure, draws the wound edges together and promotes cell stretch/microdeformation leading to cell mitosis/proliferation for wound healing. Generally, the NPWT system should provide for wound exudate to be transferred away from the wound bed and stored externally in a secure, closed canister that limits potential for exudate to be spilled in open environment.

V. BARIATRIC BED - A (0946)

Item Definition: The days of care for which the recipient requires the use of and is placed on a Bariatric Bed - A. For purposes of nursing facility reimbursement, a Bariatric Bed - A is defined as a "hospital bed, heavy duty, extra wide, weight > 350 lbs < or equal 600 lbs with mattress (HCPCS code E0303)."

NOTE: In order to be reimbursable under this service, both of the following requirements must be met:

1. The bariatric bed must be ordered by a physician; and
2. One of the following:
 - A. The recipient weighs no less than 350 pounds and no greater than 600 pounds, or
 - B. The recipient weighs less than 350 pounds, yet because of his/her height or overall body size, a standard hospital bed would not meet his/her health and safety needs.

For recipients who meet the criteria under #1 above, reimbursement for Bariatric Bed - A will be continued until the recipient's weight/body size has ceased to meet the above criteria for three consecutive months.

KEY DOCUMENTATION:

1. Physician's Orders.
2. Treatment Sheets must indicate the recipient's use of a bariatric bed and be signed off by the licensed medical professional providing the care.
3. MDS 3.0 Section K Swallowing/Nutritional Status
 - K0700.A Record height in inches Height in inches
 - K0700.B Record weight in pounds Weight in pounds
4. Physical observation by Agent, if necessary.

VI. BARIATRIC BED - B (0291)

Item Definition: The days of care for which the recipient requires the use of and is placed on a Bariatric Bed - B. For purposes of nursing facility reimbursement, a Bariatric Bed - B is defined as a "hospital bed, extra heavy duty, extra wide, with weight > 600 lbs with mattress (HCPCS E0304)."

NOTE: In order to be reimbursable under this service, both of the following requirements must be met:

1. The bariatric bed must be ordered by a physician; and
2. One of the following:
 - A. The recipient weighs more than 600 pounds, or
 - B. The recipient weighs less than 600 pounds, yet because of his/her height or overall body size, neither a standard hospital bed nor a heavy duty bed meeting the definition for Bariatric Bed - A would meet his/her health and safety needs.

For recipients who meet the criteria under #1 above, reimbursement for Bariatric Bed - B will be continued until the recipient's weight has ceased to meet the above criteria for three consecutive months.

KEY DOCUMENTATION:

1. Physician's Orders.
2. Treatment Sheets must indicate the recipient's use of a bariatric bed and be signed off by the licensed medical professional providing the care.
3. MDS 3.0 Section K Swallowing/Nutritional Status
 - K0700.A Record height in inches Height in inches
 - K0700.B Record weight in pounds Weight in pounds
4. Physical observation by Agent, if necessary.

THErapy SERVICES

Medicare guidelines for rounding to the nearest 15-minute unit may be applied to Therapy Services.

I. PHYSICAL THERAPY (0420)

Item Definition: A unit of service during which a recipient receives active physical therapy.

NOTES

1. In order to be reimbursable, physical therapy services must be:
 - a. Such that the level of complexity and sophistication, or the condition of the recipient, requires the judgment, knowledge, and skills of a qualified physical therapist¹;
 - b. Ordered by the physician after any needed consultation with a qualified physical therapist;
 - c. Performed by or under the supervision of a qualified physical therapist;
 - d. Provided with the expectation, based on the assessment made by the physician of the recipient's restorative potential after any needed consultation with the qualified physical therapist, that the recipient will improve significantly in a reasonable and generally predictable period of time;
 - e. Considered under accepted standards of medical practice to be a specific and effective treatment for the recipient's condition; and
 - f. Reasonable and necessary to the treatment of the recipient's condition.
2. Reimbursement is not available for the provision of services designed solely to maintain the recipient's current level of functioning (e.g., routine range of motion).
3. A maximum of four 15-minute units of service are reimbursable per day. In order to be reimbursed, the units of service must have been ordered and provided.
4. The Program will reimburse for an evaluation, by a qualified physical therapist, of the need for and appropriateness of physical therapy services in the same manner it

¹A "qualified physical therapist" means a person licensed by the Maryland Board of Physical Therapy Examiners or similarly licensed or registered in the state in which the service is provided.

reimburses for the therapy itself.

KEY DOCUMENTATION

1. Physician's order
2. Physical Therapy evaluation - must include the reason for referral, onset date of problem, prior and current level of functioning, assessment summary, recommendations for treatment, rehabilitative potential, and discharge plan
3. Treatment plan identifying therapeutic modalities, frequency of services (minutes per day and days per week), and short and long term goals
4. Daily service record - must include date of treatment, treatment modality, minutes of treatment for each modality and total treatment minutes. The record must be initialed daily by the qualified physical therapist, with identifying signature on the sheet. A sample daily service record is included in the Appendix of the Handbook. Facilities may use this form or an alternate format, provided all required documentation is included.
5. Physical therapy progress notes including initial assessment note, update status, and discharge instructions. Progress notes must be completed at least weekly.

II. OCCUPATIONAL THERAPY (0430)

Item Definition: A unit of service during which a recipient receives active occupational therapy.

NOTES

1. In order to be reimbursable, occupational therapy services must be:
 - a. Such that the level of complexity and sophistication, or the condition of the recipient, requires the judgment, knowledge, and skills of a qualified occupational therapist¹;
 - b. Ordered by the physician after any needed consultation with a qualified occupational therapist;
 - c. Performed by or under the supervision of a qualified occupational therapist;
 - d. For the purposes of improving or restoring functions which have been impaired by illness or injury or, if function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning;
 - e. Provided with the expectation, based on the assessment made by the physician of the recipient's restorative potential after any needed consultation with the qualified occupational therapist, that the recipient will improve significantly in a reasonable and generally predictable period of time;
 - f. Considered under accepted standards of medical practice to be a specific and effective treatment for the recipient's condition; and
 - g. Reasonable and necessary to the treatment of the recipient's condition.
2. A maximum of four 15-minute units of service are reimbursable per day. In order to be reimbursed, the units of service must have been ordered and provided.
3. The Program will reimburse for an evaluation, by a qualified occupational therapist, of the need for and appropriateness of occupational therapy in the same manner it

¹ A "qualified occupational therapist" means a person licensed by the Maryland Board of Occupational Therapy Examiners or similarly licensed or registered in the state in which the service is provided.

reimburses for the therapy itself.

KEY DOCUMENTATION

1. Physician's order
2. Occupational Therapy evaluation - must include the reason for referral, onset date of problem, prior and current level of functioning, assessment summary, recommendations for treatment, rehabilitative potential, and discharge plan
3. Treatment plan identifying therapeutic modalities, frequency of services (minutes per day and days per week), and short and long term goals
4. Daily service record - must include date of treatment, treatment modality, minutes of treatment for each modality and total treatment minutes. The record must be initialed daily by the qualified occupational therapist, with identifying signature on the sheet. A sample daily service record is included in the Appendix of the Handbook. Facilities may use this form or an alternate format, provided all required documentation is included.
5. Occupational therapy progress notes including initial assessment note, update status, and discharge instructions. Progress notes must be completed at least weekly.

III. SPEECH THERAPY (0440)

Item Definition: A unit of service during which a recipient receives active speech therapy.

NOTES:

1. In order to be reimbursable, speech therapy services must be:
 - a. Such that the level of complexity and sophistication, or the condition of the recipient, requires the judgment, knowledge, and skills of a qualified speech and language pathologist¹;
 - b. Ordered by the physician after any needed consultation with a qualified speech and language pathologist;
 - c. Performed by or under the supervision of a qualified speech and language pathologist;
 - d. For the purposes of improving or restoring functions which have been impaired by illness or injury or, if function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning;
 - e. Provided with the expectation, based on the assessment made by the physician of the recipient's restorative potential after any needed consultation with the qualified speech and language pathologist, that the recipient will improve significantly in a reasonable and generally predictable period of time;
 - f. Considered under accepted standards of medical practice to be a specific and effective treatment for the recipient's condition; and
 - g. Reasonable and necessary to the treatment of the recipient's condition.
2. A maximum of four 15-minute units of service are reimbursable per day. In order to be reimbursed, the units of service must have been ordered and provided.
3. The Program will reimburse for an evaluation, by a qualified speech and language pathologist, of the need for and appropriateness of speech therapy in the same manner it

¹A "qualified speech and language pathologist" means a person licensed by the Maryland Board of Speech Pathology Examiners or similarly licensed or registered in the state in which the service is provided.

reimburses for the therapy itself.

KEY DOCUMENTATION

1. Physician's order
2. Speech Therapy evaluation - must include the reason for referral, onset date of problem, prior and current level of functioning, assessment summary, recommendations for treatment, rehabilitative potential, and discharge plan.
3. Treatment plan identifying therapeutic modalities, frequency of services (minutes per day and days per week), and short and long term goals
4. Daily service record - must include date of treatment, treatment modality, minutes of treatment for each modality and total treatment minutes. The record must be initialed daily by the qualified speech and language pathologist, with identifying signature on the sheet. A sample daily service record is included in the Appendix of the Handbook. Facilities may use this form or an alternate format, provided all required documentation is included.
5. Speech therapy progress notes including initial assessment note, update status, and discharge instructions. Progress notes must be completed at least weekly.

APPENDIX

Department of Health and Mental Hygiene – Office of Health Services
REPORT OF ADMINISTRATIVE DAYS IN A NURSING FACILITY – DHMH 2129

NOTE: A separate form is to be submitted monthly. Please write legibly.

Dates of administrative days requested. From ____ / ____ / ____ Through ____ / ____ / ____

Facility name: _____ Phone: _____

Resident name: _____

Medical Assistance number: _____

Reclassified from NF to: Less than NF ____ ICF/MR ____ Effective date: ____ / ____ / ____

List the dates action was taken to find appropriate placement and briefly describe each.
 If resident cannot be moved, physician documentation is necessary and should be attached and noted below.

Date	Actions Taken and Outcomes

Number of administrative days requested: _____

Administrator or designee: _____
(Print Name) (Signature)

(Title) (Date)

Utilization Control Agent Certification – for UCA Use Only

UCA Representative: _____
(Please Print Name & Organization)

Days approved: _____ Reason (if different from days requested): _____

Signature: _____ Date: _____

PATIENT ASSESSMENT RECONSIDERATION

Following the onsite assessment, but before payment adjustments are made, the Agent provides each facility with assessment results for each recipient assessed. If a facility disagrees with this assessment, the facility is encouraged to request the Agent to reconsider its assessment (Reconsideration). This can be accomplished by contacting the individual reviewer assigned to the facility within two weeks of the onsite visit. If necessary, the reviewer will re-review the medical record to determine whether the original assessment finding was correct.

Issues appropriate for such informal resolution include provision of medical record documentation not in the record at the time of review. This informal Reconsideration is not a forum for resolution of issues relating to Medicaid reimbursement policy.

Facilities are strongly encouraged to employ the Reconsideration process when possible. The Agent does not submit the assessment findings to the Program immediately, but waits until the two-week reconsideration period has expired before submitting assessments. Once the assessments have been submitted to the Program, payment adjustments are automatically made, resulting in a possible loss of reimbursement to the facility. Resolution at this level before submission of assessments may prevent unnecessary adjustments and further delays in receiving appropriate reimbursements.

PROCEDURE FOR ADMINISTRATIVE REVIEW

If a facility disagrees with the determinations of the Patient Assessment adjustments as reflected in the reports, it has a right under COMAR 10.09.10.11I to request an Administrative Review. Requests for the review must be submitted in writing within thirty (30) days of receiving the reports. The request must be sent to:

**Nursing Facilities Staff Specialist
Division of Long Term Care Services
Office of Health Services
Department of Health and Mental Hygiene
First Floor
201 West Preston Street
Baltimore, Maryland 21201-2399**

All supporting documentation listed must accompany the request for Administrative Review. A request letter which does not include the supporting documentation is insufficient. Requests for Administrative Review must be received no later than thirty (30) days from the date the adjustment reports were received. Requests not received by the due date will not be considered. The following documentation must accompany each appeal item:

1. Patient Assessment Form (DHMH 4143) - clear, unaltered copy;
2. Those pages on the Remittance Advice (which follows receipt of the computer printout) reflecting an adjustment and the newly assigned Invoice Control Number (ICN); and
3. A cover letter with provider number and run date of the Adjustment Transaction Summary.

In addition to the above, the facility must submit that documentation described in the Recipient Assessment Handbook as Key Documentation for the service in question. This documentation includes but is not limited to:

1. The MDS data for the month in question and the previous MDS update;
2. Physician orders;
3. Medication and/or treatment sheets, with signatures of licensed nurses whose initials appear on the sheets;

4. Skin sheets (for appeals involving Decubitus Ulcer Care);
5. Other supporting documentation (i.e., progress notes, physical therapy notes, etc.) that may help the reviewer verify that the services were appropriate and provided according to Medicaid reimbursement criteria.

As part of the Administrative Review process, the facility must complete and submit the Patient Assessment Adjustment Worksheet using a separate sheet for each recipient. The worksheets must include the name of the recipient, Medical Assistance number, month, year, number of days of service, provider number, and the category of the service for which Administrative Review is being requested.

In lieu of requesting Administrative Review by mail, the facility may elect to submit the request electronically by sending the request to CostleyA@dhmh.state.md.us. Please note, however, that if the facility elects to request Administrative Review by e-mail, all documentation must be included in the e-mail, not mailed separately.

Upon receipt of the request and all of the supporting documentation, the Administrative Review will be conducted. Professional staff of the Office of Health Services will review each item under appeal and determine whether the facility is entitled to reimbursement for the service under review. The results of the Administrative Review will be entered into the worksheet and communicated to the facility in writing, including explanations of any denials.

If the facility agrees with the conclusions of the Administrative Review, any amount due will be refunded via a future Program Remittance Advice. Should the facility disagree with the results, it may request an appeal before the Maryland Office of Administrative Hearings pursuant to COMAR 10.09.36.

A facility may elect to bypass the Administrative Review process and move directly to a provider hearing. If this course is chosen, the request should be submitted in writing within thirty (30) days of receipt of the adjustment reports. Such requests should be submitted to:

Susan J. Tucker, Executive Director
Office of Health Services
201 West Preston Street - Room 127
Baltimore, Maryland 21201-2399

The request will be referred to the Office of Administrative Hearings, which will advise the facility about date, time, and location of the hearing. If there are any questions regarding the appeal process please call the Nursing Facilities Staff Specialist, Office of Health Services, at 410-767-1736.