Department of Health and Mental Hygiene

Maryland Medical Assistance Program

Nursing Facility Reimbursement Manual

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Overview

The purpose of this manual is to provide an overview of the nursing facility reimbursement system. Use this in conjunction with the Uniform Billing (UB04) Nursing Facility Billing Instructions. These instructions are available at the link at the end of this section. Specifically, this manual covers:

- General Reimbursement Information,
- Minimum Data Set 3.0 and Resident Records,
- Facility Responsibilities, and
- Active Revenue Codes for Nursing Facility Billing.

Information in this manual is based on COMAR 10.09.10. Please direct all questions regarding this manual to the Nursing Facility Program to dhmh.maltcf@maryland.gov.

Please visit our website for additional information.

https://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Nursing%20Home%20Services.aspx

General Reimbursement Information

Types of Payments

The Department pays nursing facilities for both days of service and certain medical equipment and supplies. The different types of days of service the Department reimburses for are:

- Resident Care Day,
- Resident Ventilator Care Day (for facilities authorized by the Office of Health Care Quality to provide ventilator care),
- Administrative Day,
- Therapeutic Bed Hold Day, and
- Coinsurance Day.

Medicaid pays a facility-specific Resident Care Day for Medicaid residents. Rates are based on the average acuity of the facility.[1] Residents receiving ventilator care in facilities authorized by the Office of Health Care Quality to provide ventilator care are exceptions. The Department reimburses one separate per diem for these residents due to their high acuity.

Other payments are made based on medical equipment and supplies purchased or rented to serve particular residents. These include Class A and B support surfaces, bariatric beds (A and B), power wheel chairs and negative pressure wound therapy equipment and supplies.

[1] There are no additional adjustments based on light, moderate, heavy or heavy special levels of care.

Descriptions of each revenue code including rules and additional records to maintain are listed under Active Revenue Codes for Nursing Facility Billing.

Payments are not subject to cost settlement.

Facility Rates

A facility's Resident Care Day rate is comprised of four cost centers:

- Administrative and routine (e.g., administration, training, laundry, housekeeping),
- Other patient care (e.g., pharmacy, food, social services, recreation),
- Capital (real estate tax and fair rental value), and
- Nursing services (all direct care).

The Department calculates annual regional prices on a State fiscal year basis for administrative and routine costs as well as other patient care costs. Facility-specific capital rates are set based on real estate taxes and fair rental value. These rates generally remain constant throughout the year.

Since the acuity of residents in a facility fluctuates, the Department adjusts the nursing service rates quarterly. This allows flexibility to keep up with ongoing direct service costs. Each quarter, the Department uses case mix to drive rate changes. If a facility's case mix increases at a higher rate than the statewide average, their nursing services rate increases. Information regarding acuity of residents in each facility is captured through the Minimum Data Set 3.0 assessment.

The Department distributes a quarterly facility-specific rate letter. The rate letter will have a specific date range for dates of service in which those rates are valid. Please see the sample in Appendix 1. Shadow Rate Letter (Template).

Minimum Data Set (MDS) 3.0 and Resident Records

Submitting MDS Data

All facilities complete and submit MDS 3.0 data on each resident through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing System. Medicare and Medicaid use this information to reimburse facilities.[2]

Once submitted, the Department analyzes all resident roster data, assigns a RUG score to each resident and determines a Statewide and facility specific case mix. Reimbursement for nursing services is based on the case mix, or average acuity, of Medicaid residents in each facility. At the end of each quarter, the Department uses this facility-specific Medicaid case mix, compares it to the rest of the State, and assigns a facility specific rate.

[2] Please note that the Maryland Monthly Assessment, which captures selected sections of the MDS on a monthly basis, is no longer required.

To ensure accuracy, facilities must review their facility's resident roster. Please see Facility Responsibilities for more information.

MDS Validation Process

The Department will validate MDS data on a facility-specific basis to ensure confidence in submitted MDS data. Additional records may be required to validate claims. Please see the list of recommended and required records for each service billed.

Facility Responsibilities

Secure Email Address

Each facility must retain at least one email address on file with the Department. The Department distributes protected health information to each facility during the resident roster review process. The safest and most efficient method to send information is *via* secure, encrypted email. Printed versions will be mailed to your facility if an email address has not yet been provided.

These email addresses receive confidential resident rosters quarterly. To avoid rosters being lost during staff turnover and to ensure the safe transfer of protected health information, the Department recommends each facility develop a facility-specific email account, such as MedicaidNumber@FacilityName.com to which the facility can then limit access to pertinent staff. It is important that each facility implements procedures to maintain control over access to these files. Note that personal email accounts are not acceptable (e.g., Gmail, hotmail, yahoo, AOL).

If your facility has not already done so, please contact **mdhelpdesk@mslc.com** for more information.

Resident Roster Review Process

Nursing facilities have an opportunity to ensure that their submitted MDS data is accurate. Resident rosters are created at the end of each quarter and distributed to each facility for review. A resident roster is a list of all residents with active MDS assessments during the most recent quarter in each facility. An average acuity, or case mix index, is established for all Medicaid residents and all residents based on these MDS assessments. These are crucial components in determining Nursing Services rates each quarter.

All changes must be submitted directly through the QIES Assessment Submission and Processing System. Written changes are not accepted.

The resident roster review schedule and the Resident Roster Correction Process Manual are available at:

https://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Nursing%20Home%20Services.aspx

Maintaining Resident Records

In addition to submitting MDS 3.0 data, each facility must also maintain certain other information for each resident. This documentation includes, but is not limited to, plans of care, physician's orders, physician, nursing, and other disciplinary notes, consultations, and medication and treatment sheets. Additional documentation requirements are noted under each revenue code section of this manual.

The Department recommends documentation be kept on site for a minimum of six months from the last date of service being billed for that resident. This information is commonly requested during audits for recent claims. Note that all documentation must be kept for each participant for the previous six years and must be made available to the Department or its designee upon request.

Active Revenue Codes for Nursing Facility Billing

The following revenue codes may be billed by a nursing facility. Please note that resident records must be kept on file and available to the Department and its contractor for audit purposes. Previously, additional add-ons were billable. Under the RUGs-based methodology for paying nursing services, many of these add-ons are now included in the Resident Care Day rate for each facility and may not be billed separately.

The appropriate code may be billed for each day the resident received the service. Please note that no payment may be made for the date of discharge, unless the resident was admitted and discharged on the same day.

Please see the Uniform Billing (UB04) Nursing Facility Billing instructions for more information on submitting claims.

Revenue Code Title	HIPAA Compliant Revenue Code Description	Revenue Code
Daily Rates		
Resident Care Day	Rm & Brd Semi-Private - General	0120
Resident Ventilator Care Day	Rm & Brd Semi-Private - Other	0129
Administrative Day	Administrative Day	0169
Therapeutic Bed Hold Day	Leave of Absence Therapeutic Lv	0183
Coinsurance Day	All Inclusive Rm & Brd	0101
Other Costs (billed in addition to Daily Rates)		
Class A Support Surface	DME – General	0290
Class B Support Surface	DME – Other	0299
Bariatric Bed A	Complex Medical Equip-Rout	0946
Bariatric Bed B	DME – Rental	0291
Negative Pressure Wound Therapy	Medical/Surgical Supplies and Devices – General Classification	0270
Power Wheel Chairs	Complex Medical Equipment	0947

General Requirements for All Billing

The resident must be financially eligible for Long Term Care Medical Assistance on the date of service for a claim to be paid. Except for Administrative Days and Coinsurance Days, the resident shall be determined to meet a nursing facility level of care by the Department or the Utilization Control Agent.

The facility must keep records on file and available to the Department or its designee to substantiate the claim. Recommended documentation includes, but is not limited to:

- Minimum Data Set,[3]
- plan of care,
- medication sheets,
- treatment sheets,
- physician's orders,
- physician, nursing, therapy, and other applicable professional progress notes,
- results of laboratory tests, and
- consultation reports.

Resident Care Day (0120)

Bill the Resident Care Day revenue code for each date of service in which a resident, who was not receiving ventilator care, was present in the facility and received nursing services. Claims for residents receiving ventilator care in a facility authorized by the Office of Health Care Quality to provide ventilator care are submitted separately.

This rate will change quarterly. Please review your facility's rate letter prior to billing.

Ventilator Resident Care Day (0129)

Bill the Ventilator Resident Care Day revenue code for any day, or part of day, in which a resident receives artificial ventilation of the lungs by mechanical means through a ventilator. This revenue code includes payment for nursing time as well as additional costs associated with this procedure.

Administrative Days (0169)

Bill the Administrative Day revenue code for each day of care provided to a resident who has been determined by the Department or its designee, to no longer require a nursing facility level of care. Please note that if the resident appeals a denial of continued nursing facility level of care before the date the decision became effective, the facility may continue to bill at the full applicable rate pending the outcome of the administrative hearing.

The facility must meet the requirements under COMAR 10.09.10.16-1D including documentation of discharge planning and placement efforts, as appropriate. The Program's Nursing Home Transmittal Nos. 201 and 233 describes the documentation requirements and process for requesting Administrative Days

[3] Note that the Maryland Monthly Assessment will no longer be required for services rendered on or after January 1, 2015.

in detail.[4] The DHMH 2129 form must be completed (please see Appendix 2. DHMH 2129 Form (Template)).

Additional Records to Maintain

Social work notes supporting the claim must be maintained and made available upon request.

Therapeutic Bed Hold Day – Leave of Absence (0183)

Bill the Therapeutic Bed Hold Day - Leave of Absence revenue code for each day in which a resident is on a home visit extending beyond the midnight bed census or participating in a State-approved inpatient therapeutic or rehabilitative program.

Reimbursement is allowed for up to 18 days per calendar year. If a resident 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 if the resident does not remain out overnight.

Additional Records to Maintain

Please keep records on file and available to the Department to substantiate this type of claim. The following documentation is required.

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. Clear documentation of the dates of absence within the medical record and/or resident plan of care.

Coinsurance Day (0101)

For participants in both Medicare Part A and Medicaid, Medicaid pays coinsurance claims for days 21-100 of a nursing facility stay. This payment is the difference between the Medicare Part A rate and the Medicaid Statewide average (if greater than the Part A rate).

The Uniform Billing (UB04) Nursing Facility Billing Instructions has a step-by-step guide on this process. The manual is available at:

https://mmcp.dhmh.maryland.gov/SitePages/Billing%20Instructions.aspx

Please see the Coinsurance Worksheet at the website below on payments for this revenue code. This worksheet also instructs providers whether billing should be completed electronically or by paper.

Note that the rates established by CMS and the Department change throughout the year (usually on January 1 and July 1).

https://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Nursing%20Home%20Services.aspx

[4] Transmittals are available at https://mmcp.dhmh.maryland.gov/MCOupdates/SitePages/Home.aspx.

Support Surface — A (0290)

Bill the Support Surface — A revenue code for each day of care provided to a resident who receives services while using a Class A Support Surface. This revenue code should be billed in conjunction with the appropriate day of service.

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). Specifically, mattresses classified under Healthcare Common Procedure Coding System (HCPCS) codes E0277, E0373, E1399 and the RIK fluid mattress are covered.[5] Additionally, the surface must have an inflated cell depth of at least five inches.

Rules

The following rules apply when billing for this service. Please see Appendix 3. Decubitus Ulcer Care for more information regarding Decubitus Ulcer Care.

1. The resident'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.
2. The resident's decubitus ulcer must meet one of the following criteria (for purposes of reimbursement, staging definitions are consistent with the definitions presented in this Reimbursement Manual under Appendix 3. Decubitus Ulcer Care).
    a. Resident 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;
    b. Resident 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
    c. Resident 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 resident's needs.
3. The decubitus condition must be present upon the resident'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 resident's status, and of the resident's treatment plan consistent with the severity of the resident's condition.
4. The support surface must meet the above definition and be ordered by a physician.

[5] Information regarding Healthcare Common Procedure Coding System (HCPCS) is available at http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html.

5. Specific decubitus ulcer treatment must be recorded in the medical record and provided according to physician's orders.
6. The resident'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.

Additional Records to Maintain

In addition to the documentation described under General Requirements, the facility shall also maintain the following:

1. Description of the support surface in use,
2. Weekly Skin Sheets, documented by a licensed nurse must be specific to size (circumference and depth, in inches or centimeters), color and any drainage of the ulcer. Prescribed treatment and the resident's response to treatment must be included, and
3. Documentation of management of the resident'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.

Support Surface — B (0299)

Bill the Support Surface — B revenue code for each day of care provided to a resident who receives services while using a Class B Support Surface. This revenue code should be billed in conjunction with the appropriate day of service.

A Class B Support Surface is an air-fluidized bed, approved as a Group 3 Pressure Reducing Support Surface by the Medical Policy of the Medicare Durable Equipment Regional Carriers (DMERC). The Class B Support Surface is classified under HCPCS code E0194.

Rules

The following rules apply when billing for this service. Please see Appendix 3. Decubitus Ulcer Care for more information.

1. The resident'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.
2. The resident's decubitus ulcer must meet one of the following criteria:
    a. Resident 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 resident; or

    b. Resident is in the initial 60 days of post-operative recovery from myocutaneous flap or graft surgery for a decubitus ulcer on the trunk.[6]
3. The decubitus condition must be present upon the resident'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 resident's status, and of the resident's treatment plan consistent with the severity of the resident's condition.
4. The support surface must meet the above definition and be ordered by a physician.
5. Specific decubitus ulcer treatment must be recorded in the medical record and provided according to physician's orders.
6. The resident'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.

Additional Records to Maintain

In addition to the documentation described under General Requirements, the facility shall also maintain the following:

1. Description of the support surface in use,
2. Weekly Skin Sheets, documented by a licensed nurse must be specific to size (circumference and depth, in inches or centimeters), color and any drainage of the ulcer. Prescribed treatment and the resident's response to treatment must be included, and
3. Documentation of management of the resident'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.

Bariatric Bed — A (0946)

Bill the Bariatric Bed - A revenue code for each day of care provided to a resident who requires the use of and is placed on a Bariatric Bed - A. This revenue code should be billed in conjunction with the appropriate day of service.

For purposes of nursing facility reimbursement, a Bariatric Bed - A is defined as a hospital bed, heavy duty, extra wide, for residents who weigh no less than 350 pounds and no greater than 600 pounds with mattress (HCPCS code E0303).

[6] Staging definitions are consistent with the definitions presented in this Reimbursement Manual under Decubitus Ulcer Care in Appendix 3.

Rules

Bariatric Bed A is reimbursable only under one of the following conditions:

- The resident weighs no less than 350 pounds and no greater than 600 pounds, or
- The resident 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.

Reimbursement for Bariatric Bed - A will continue until the resident's weight/body size has ceased to meet the above criteria for three consecutive months.

Additional Records to Maintain

In addition to the documentation described under General Requirements, physical observation by a member of the Department or its designee may be required.

Bariatric Bed — B (0291)

Bill the Bariatric Bed - B revenue code for each day of care provided to a resident who requires the use of, and is placed on, a Bariatric Bed - B. This revenue code should be billed in conjunction with the appropriate day of service.

For purposes of nursing facility reimbursement, a Bariatric Bed - B is defined as a hospital bed, extra heavy duty, extra wide, with weight greater than 600 pounds with mattress (HCPCS E0304).

Rules

Reimbursement for Bariatric Bed B may be made only under one of the following circumstances:

- The resident weighs more than 600 pounds, or
- The resident 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 residents who meet the criteria above, reimbursement for Bariatric Bed - B will continue until the resident's weight/body size has ceased to meet the above criteria for three consecutive months.

Additional Records to Maintain

In addition to the documentation described under General Requirements, physical observation by a member of the Department or its designee may be required.

Negative Pressure Wound Therapy (0270)

Bill the Negative Pressure Wound Therapy (NPWT) revenue code for the use of a NPWT pump rental, dressings and canister. This revenue code should be billed in conjunction with the appropriate day of service.

Rules

The following rules apply when billing for this service. The resident must have one or more of the following conditions:

1. Stage III or IV Pressure Ulcers,
2. Neuropathic (Diabetic Ulcers),
3. Venous Insufficiency Ulcers,
4. Surgically Created (Dehiscence),
5. Enteric Traumatic Wound Flap/Graft only, and/or
6. Fistulae.

The condition must be present upon the resident's admission to the facility or be determined by the Department or its contractor not to be the result of inadequate or inappropriate care by the facility. If a wound develops despite preventive treatment measures, the facility may be reimbursed if it provides sufficient documentation showing that development was inevitable.

The medical record must demonstrate one of the following:

1. Traditional treatment modalities were insufficient to heal the wound, or
2. Traditional treatments are likely to be ineffective or contraindicated due to the resident's medical condition or the nature of the wound.

In addition to the documentation listed under General Requirements, the facility shall maintain weekly skin sheet documentation. 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 resident's response to treatment,

Coverage will continue as long as documentation exists in the resident's chart that shows wound progress measured by decrease in wound dimension of length, width, depth, tunnels or undermining.

If there is no measurable decrease in wound dimensions, document changes made to the care plan to address the following: 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 is covered for therapy systems that can demonstrate the following.

1. Controlled, regulated negative pressure to the wound is delivered using a software-controlled therapy unit that allows 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 received at the wound site to ensure prescribed amounts of pressure is received to the wound bed.

2. 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. 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.

Power Wheel Chairs (0947)

The Department must preauthorize the purchase or repair of a power wheel chair. A preauthorization request must be submitted to the Department on the required form (please see Rules below). This form must be completed in full.

If approved, the facility will receive notification from the Department. The notification will include the approval decision, the amount approved to bill. Once a facility receives this notification, they will bill using the UB04. The resulting claim is considered payment in full.

Rules

The following steps must be taken to receive preauthorization for power wheel chair costs and repairs.

1. Providers must request preauthorization from the Department for a power wheelchair or wheelchair repair, in a format designated by the Department. Please see Appendix 4. Power Wheel Chair Request Form (Template). This form is also available for download at:

   https://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Nursing%20Home%20Services.aspx

   Mail this form and any additional information to:

   Division of Long Term Care Services
   201 W Preston St.
   Room 120-G
   Baltimore, MD 21201
   Fax: (410) 333-7803

2. The Department determines:
   a. The medical necessity of the wheelchair or wheel chair repair,
   b. Whether the nursing home is conducive to wheel chair traffic, and
   c. The maximum allowable cost of the wheel chair or wheel chair repair.
3. The Department sends a preauthorization letter to the provider approving or denying the wheel chair or wheel chair repair. Without this letter, payment will not be authorized.

Additional Records to Maintain

In addition to documentation listed under General Requirements, documentation includes:

1. A copy of the signed Power Wheel Chair Preauthorization Request Form, and
2. Invoice for each item purchased.

Appendices

Appendix 1. Shadow Rate Letter (Template)

Rate Letter Summary
SAMPLE NURSING FACILITY
Provider #: 1234567890

Sent to: <insert email addresses>

Effective Dates: January 1, 2015 to March 31, 2015

Revenue Code Title	HIPAA Compliant Revenue Code Description	Revenue Code	Rate
Daily Rates			
Resident Care Day	Rm & Brd Semi-Private - General	0120	Changes Quarterly
Administrative Day	Administrative Day	0169	Changes Quarterly
Therapeutic Bed Hold Day	Leave of Absence Therapeutic Lv	0183	Changes Quarterly
Coinsurance Day	All Inclusive Rm & Brd	0101	*
Other Costs (billed in addition to Daily Rates)			
Class A Support Surface	DME – General	0290	Fixed rate
Class B Support Surface	DME – Other	0299	Fixed rate
Bariatric Bed A	Complex Medical Equip-Rout	0946	Fixed rate
Bariatric Bed B	DME – Rental	0291	Fixed rate
Negative Pressure Wound Therapy	Medical/Surgical Supplies and Devices – General Classification	0270	Fixed rate
Power Wheel Chair	Complex Medical Equipment	0947	Preauthorization required
Ventilator Resident Care Day	Respiratory - Other	0129	For authorized providers only; Changes Quarterly

* Please see the Coinsurance Worksheet available at:
https://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Nursing%20Home%20Services.aspx

Appendix 2. DHMH 2129 Form (Template)

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: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] **(Note: M.A. # is 11 digits)**

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:** _____

DHMH 2129 (Rev. 2/2010)

Appendix 3. Decubitus Ulcer Care

The Department reimburses certain additional revenue codes (Class A and Class B Support Surfaces) for residents with a Stage III or IV Decubitus Ulcer, Stasis Ulcer or similar condition. This includes a condition 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. Traumatic injuries such as lacerations or burns are excluded.

Note: The Department does not reimburse separately for this nursing service.

Classification:

- Stage I - Demarcated, reddened area of the skin characterized by unbroken skin surface that feels warm, blanches to the touch and does not fade within thirty minutes after pressure has been removed.
- 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.
- Stage III - Full thickness loss of skin that may or may not include the subcutaneous tissue level, produces serosanguinous drainage and is surrounded by inflamed skin.
- Stage IV - Full thickness loss of skin with invasion of deeper tissue such as fascia, muscle, tendon or bone, consisting of a deep, broken area with necrosis and white, 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.
- Unstageable – A known or suspected deep tissue injury that is unstageable due to eschar or slough covering the area.

A facility may bill for Class A and Class B Support Surfaces if decubitus ulcer care was administered. 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 are 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 the physician has ordered “Op-site” or similar treatment, the facility will be reimbursed for the day the treatment was actually applied or reapplied. Frequent observation is necessary.
4. Irrigations
5. Heat lamp
6. Oxygen

Appendix 4. Power Wheel Chair Request Form (Template)

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL ASSISTANCE PROGRAM
PREAUTHORIZATION REQUEST
POWER WHEELCHAIRS FOR NURSING HOME RESIDENTS
INCLUDING REPAIRS

Section I – Recipient Information

MA Number _____

Last Name_____ First Name_____ DOB_____ Sex____

Is discharge anticipated? □ Yes □ No If yes, approximate discharge date_____

Section II – Facility Information

Facility Name_____Provider Number_____

Address_____

Request Date_____ Contact_____Telephone_____

Section III – Requested Equipment/Repairs

# Units	HCPCS	Description	Program Use Only	
			# App	Denial Reason/Comment

For repairs only: was the equipment for which repair is requested purchased before the recipient entered the nursing home? □ Yes □ No

Section IV –Medical/Functional Information

Attending Physician Name_____

Diagnoses related to need for power wheelchair

Dx Code	Description	Dx Code	Description

Recipient's ability to walk with or without the use of a cane or brace (check one in each column)

	In Room	On Unit
Independent (occasional or no assistance needed)		
Supervision (oversight, encouragement, cuing)		
Limited assistance (recipient highly involved, primarily needs non-weight-bearing physical help)		
Extensive assistance (some involvement by recipient, usually needs weight-bearing support, occasional full staff performance)		
Total dependence (full staff performance)		

ADL support needed for walking with or without the use a cane or brace (check one in each column)

	In Room	On Unit
No setup or physical help from staff		
Setup help only		
One person physical assist		
Two + person physical assist		

Furthest distance recipient able to walk without sitting down (check one):

□ Less than 10 ft □ 10 – 25 ft □ 25 – 50 ft □ 51 – 149 ft □ 150+ ft

Is the recipient able to self-propel a manual wheelchair? □ Yes □ No If no, please detail the medical and/or functional problems that prevent the recipient from being able to independently propel a manual wheelchair_____

_____

_____

Is the recipient able to independently operate the controls of a power wheelchair in a safe manner? □ Yes □ No If no, describe the medical and/or functional problems that prevent the recipient from being able to independently operate a power wheelchair_____

_____

_____

Additional information to support medical necessity for equipment_____

_____

_____

IMPORTANT! Please attach a copy of the physician's order. The request will not be considered without a valid physician's order that specifies each equipment item requested.

I certify that the above information is true to the best of my ability. I also certify that the facility in which this equipment is to be used can safely accommodate the use of the wheelchair.

_____	_____	_____	_____
Signature	Printed Name	Title	Date