STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
January 21, 2016

To: Nursing Home Administrators

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

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

Re: Interim changes to Medical Eligibility Review, DHMH 257 processing and Administrative Day requests

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Per the previous transmittal sent to providers on January 12, 2016, Telligen will be assuming responsibility for performing utilization review services formerly conducted by Delmarva Foundation for Medical Care. The Department is working diligently with both Delmarva and Telligen to implement a smooth transition. To bridge the transition between the two vendors, the Department will take over certain responsibilities listed in this memorandum.

Delmarva will accept and process all submissions of the documents referenced in this memorandum through close of business Friday, January 22, 2016.

Beginning Monday, January 25, 2016, fax all requests directly to the Department at: (410) 333-5213. Please note this is a temporary fax number.

The Department will process all Medical Eligibility Reviews (MERs) formerly submitted through iEXCHANGE. This includes the DHMH 3871 and DHMH 3871b (including additional documentation). Please do not resubmit requests previously submitted to Delmarva.

In addition to MERs, the Department will also complete certification for DHMH 257 forms (Long Term Care Activity Report) to begin payment for full MA coverage or otherwise require UCA approval. All other DHMH 257 request reasons should follow the current submission process.

Finally, the Department will also process Administrative Days requests for nursing facilities, chronic and special pediatric hospitals (DHMH 2129 for nursing facilities).

All submissions must be complete and include all necessary attachments and be accompanied by the Department's Fax Cover Sheet. The Department updated these forms to expedite the review process. **The Department will return all requests that include old or incomplete forms, lack necessary supporting documentation, or do not include the Fax Cover Sheet.**

All forms are attached to this memorandum.

We appreciate your patience during this transition. Any general questions regarding the transition may be directed to dhmh.maltcf@maryland.gov.

cc: Nursing Home Liaison Committee

STATE OF MARYLAND

DHMH

Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

FAX COVER SHEET

SENDER NAME _____
SENDER ORGANIZATION _____
SENDER FAX # _____
SENDER E-MAIL _____
SENDER PHONE # _____
APPLICANT/RECIPIENT NAME _____
PAGES (including cover sheet) _____

TYPE OF REQUEST

☐ Medical Eligibility Review request for Nursing Facility services (DHMH 3871B; DHMH 4345 and other PASRR documentation if required; DHMH 3871B Addendum if desired)

☐ Medical Eligibility Review request for Medical Adult Day Care Waiver (DHMH 3871B from hospitals, nursing facilities and Medical Day Care Center redeterminations only)

☐ Medical Eligibility Review request for Chronic or Special Pediatric Hospital services (DHMH 3871 or DHMH 3871B/Vent Questionnaire)

☐ Certification (DHMH 257) processing for begin pay for full Medicaid or otherwise require UCA approval

☐ Administrative Days request for nursing facilities (DHMH 2129)

☐ Administrative Days request for chronic or special pediatric hospitals (DHMH 1288)

The Department will return all requests that include old or incomplete forms or do not include the Fax Cover Sheet.

201 W. Preston Street – Baltimore, Maryland 21201
Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.maryland.gov

DHMH 3871B
Maryland Medical Assistance
Medical Eligibility Review Form

Part A – Service Requested (*indicates required field)

*1. Requested Eligibility Date_____ 2. Admission Date_____

*3. Check Service Type Below:

☐ Nursing Facility-please attach PASRR documentation if necessary (see Part F)

☐ Program of All-Inclusive Care for the Elderly (PACE) ☐ Brain Injury Waiver

☐ Chronic Hospital/Special Hospital vent dependent only (all other CH/SH use 3871) – please attach the Supplemental Ventilator Questionnaire

☐ Model Waiver vent dependent only (all other MW use 3871) – please attach the Supplemental Ventilator Questionnaire

☐ Medical Adult Day Care (new applicants currently placed in a hospital or nursing facility only)

*4. Check Type of Request

☐ Initial ☐ Conversion to MA ☐ Medicare ended ☐ MCO disenrollment

☐ Readmission – bed reservation expired (NF) ☐ Transfer new provider ☐ Update expired LOC ☐ Corrected Date

☐ Significant change from previously denied request ☐ Recertification (MW/PACE only)

☐ Advisory (please include payment)

*5. Contact Name_____ *Phone_____ *Fax_____

*E-Mail_____ *Organization/Facility_____

Part B – Demographics (* indicates required field)

*1. Client Name: Last _____First _____ MI ___ Sex: M F (circle)

*SS# _____- ____- _____ * MA # _____ *DOB _____

*2. Current Address (check one) ☐ Facility ☐ Home

*Address _____*City _____*State_____ *ZIP_____ *Phone_____

Nursing Facility name (if applicable) _____Provider #_____

If in acute hospital, name of hospital_____

*3. Next of Kin/ Representative

*Last name _____ *First Name _____ *MI _____

*Address _____ *City_____ *State____ *ZIP_____ *Phone_____

*4. Attending Physician

*Last name _____ *First Name _____ MI _____

Address _____ *City_____ *State_____ *ZIP_____ *Phone_____

Part C – Diagnoses

*Primary diagnosis related to the need for requested level of care	*ICD-10 Code	*Description
Other active diagnoses related to the need for requested level of care	Descriptions	

Applicant Name _____

Part D – Skilled Services:

Requires a physician's order. Requires the skills of technical or professional personnel such as a registered nurse, licensed practical nurse, respiratory therapist, physical therapist, and/or occupational therapist. The service must be inherently complex such that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. Items listed under Rehabilitation and Extensive Services may overlap.

Table I. Extensive Services (serious/unstable medical condition and need for service)

Review Item	# Days Required
1. Tracheotomy Care: All or part of the day	
2. Suctioning: Not including routine oral-pharyngeal suctioning, at least once a day	
3. IV Therapy: Peripheral or central (not including self-administration)	
4. IM/SC Injections: At least once a day (not including self-administration)	
5. Pressure Ulcer Care: Stage 3 or 4 and one or more skin treatments (including pressure-relieving bed, nutrition or hydration intervention, application of dressing and/or medications)	
6. Wound Care: Surgical wounds or open lesions with one or more skin treatments per day (e.g., application of a dressing and/or medications daily)	
7. Tube Feedings: 51% or more of total calories or 500 cc or more per day fluid intake via tube	
8. Ventilator Care: Individual would be on a ventilator all or part of the day	
9. Complex respiratory services: Excluding aerosol therapy, spirometry, postural drainage or routine continuous O2 usage	
10. Parenteral Feeding or TPN: Necessary for providing main source of nutrition.	
11. Catheter Care: Not routine foley	
12. Ostomy Care: New	
13. Monitor Machine: For example, apnea or bradycardia	
14. Formal Teaching/Training Program: Teach client or caregiver how to manage the treatment regime or perform self care or treatment skills for recently diagnosed conditions (**must be ordered by a physician)**	

Table II. Rehabilitation (PT/OT/Speech Therapy services) Must be current ongoing treatment.

Review Item	# Days Required
15. Extensive Training for ADLs. (restoration, not maintenance), including walking, transferring, swallowing, eating, dressing and grooming.	
16. Amputation/Prosthesis Care Training: For new amputation.	
17. Communication Training: For new diagnosis affecting ability to communicate.	
18. Bowel and/or Bladder Retraining Program: Not including routine toileting schedule.	

Part E – Functional Assessment

Review Item	
FUNCTIONAL STATUS: Score as Follows **0 = Independent:** No assistance or oversight required **1 = Supervision:** Verbal cueing, oversight, encouragement **2 = Limited assistance:** Requires hands on physical assistance **3 = Extensive assistance:** Requires full performance (physical assistance and verbal cueing) by another for more than half of the activity. **4 = Total care:** Full activity done by another	**Score Each Item (0-4)**
1. Mobility: Purposeful mobility with or without assistive devices.	
2. Transferring: The act of getting in and out of bed, chair, or wheelchair. Also, transferring to and from toileting, tub and/or shower.	
3. Bathing (or showering): Running the water, washing and drying all parts of the body, including hair and face.	
4. Dressing: The act of laying out clothes, putting on and removing clothing, fastening of clothing and footwear, includes prostheses, orthotics, belts, pullovers.	

Applicant Name _____

5. Eating: The process of putting foods and fluids into the digestive system (including tube feeding).	
6. Toileting: Ability to care for body functions involving bowel and bladder activity, adjusting clothes, wiping, flushing of waste, use of bedpan or urinal, and management of any special devices (ostomy or catheter). This does not include transferring (See transferring item 16 above).	
CONTINENCE STATUS: Score as Follows **0 = Independent:** Totally continent, can request assistance in advance of need, accidents only once or twice a week or is able to completely care for ostomy. **1 = Dependent:** Totally incontinent, accidents three or more times a week, unable to request assistance in advance of need, continence maintained on toileting schedule, indwelling, suprapubic or Texas catheter in use or unable to care for own ostomy.	**Score Each Item (0-1)**
7. Bladder Continence: Ability to voluntarily control the release of urine from the bladder	
8. Bowel Continence: Ability to voluntarily control the discharge of stool from the bowel.	

Review Item	**Answer**	
Cognitive Status (Please answer Yes or No for EACH item.)	**Y**	**N**
9. Orientation to Person: Client is able to state his/her name.	☐	☐
10. Medication Management: Able to administer the correct medication in the correct dosage, at the correct frequency without the assistance or supervision of another person.	☐	☐
11. Telephone Utilization: Able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.	☐	☐
12. Money Management: Can manage banking activity, bill paying, writing checks, handling cash transactions, and making change without the assistance or supervision of another person.	☐	☐
13. Housekeeping: Can perform the minimum of washing dishes, making bed, dusting, and laundry, straightening up without the assistance or supervision of another person.	☐	☐

14. Brief Interview for Mental Status (BIMS): Was the examiner able to administer the complete interview? If yes, indicate the final score. If no, indicate reason. (Examination should be administered in a language in which the client is fluent.)	☐ Yes Score_____ ☐ No Check one of the following: ☐ Hearing Loss ☐ Applicant is rarely/never understood ☐ Language Barrier ☐ Refused ☐ Other (specify)_____

Behavior (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
15. Wanders (several times a day): Moves with no rational purpose or orientation, seemingly oblivious to needs or safety.	☐	☐
16. Hallucinations or Delusions (at least weekly): Seeing or hearing nonexistent objects or people, or a persistent false psychotic belief regarding the self, people, or objects outside of self.	☐	☐
17. Aggressive/abusive behavior (several times a week): Physical and verbal attacks on others including but not limited to threatening others, hitting, shoving , scratching, punching, pushing, biting, pulling hair or destroying property.	☐	☐
18. Disruptive/socially inappropriate behavior (several times a week): Interferes with activities of others or own activities through behaviors including but not limited to making disruptive sounds, self-abusive acts, inappropriate sexual behavior, disrobing in public, smearing/throwing food/feces, hoarding, rummaging through other's belongings, constantly demanding attention, urinating in inappropriate places.	☐	☐
19. Self-injurious behavior (several times a month): Repeated behaviors that cause injury to self, biting, scratching, picking behaviors, putting inappropriate object into any body cavity, (including ear, mouth, or nose), head slapping or banging.	☐	☐

Communication (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
20. Hearing Impaired even with use of hearing aid: Difficulty hearing when not in quiet setting, understands conversations only when face to face (lip-reading), can hear only very loud voice or totally deaf.	☐	☐
21. Vision Impaired even with correction: Difficulty with focus at close range, field of vision is severely limited (tunnel vision or central vision loss), only sees light, motion, colors or shapes, or is totally blind.	☐	☐
22. Self Expression: Unable to express information and make self understood using any means (with the exception of language barrier).	☐	☐

23. Please provide any additional information that you believe supports that the client's health care needs cannot be safely met outside a nursing facility or in the absence of MADC, PACE, or Waiver services (use an addition sheet if necessary). You are strongly encouraged to use the 3871B Addendum and/or attach medical records for this purpose.

Part F – For Nursing Facility Applicants Only - ID/RC/MI Please Complete the Following

Review Item - If any of the below questions are answered Yes, please complete and attach the full Level I screen (DHMH 4345). If the Level I screen indicates that a Level II evaluation is necessary, please attach either the Categorical Advance Group Determination Form or certification that the person has been approved for admission under PASRR.	**Answer** Y	N
1. Is there a diagnosis or presenting evidence of intellectual disability/related condition (ID/RC), or has the client received services related to intellectual disability/related condition within the past two years?	☐	☐
2. Is there any presenting evidence of mental illness (MI)?	☐	☐
a. If yes, check all that apply. ___ Schizophrenia ___ Personality disorder ___ Somatoform disorder ___ Panic or severe anxiety disorder ___ Mood disorder ___ Paranoia ___ Other psychotic or mental disorder leading to chronic disability		
3. Has the client received inpatient services for mental illness within the past two years?	☐	☐
4. Is the client on any medication for the treatment of a major mental illness or psychiatric diagnosis? a. If yes, is the mental illness or psychiatric diagnosis controlled with medication?	☐ ☐	☐ ☐
5. Is the client a danger to self or others?	☐	☐

Part G – Certification

1. Signature of Person Completing Form: _____ Date_____

Printed Name_____ Title_____

I certify to the best of my knowledge the information on the form is correct.

Signature of Health Care Professional: _____Date_____

Printed Name_____ Title_____

UCA/DHMH Use Only ☐ Approved ☐ Denied Date of Decision_____

Certification Period _____

Signature_____ Date Signed_____

Print Name_____ Title_____

DHMH 3871B Addendum

Maryland Medical Assistance
Medical Eligibility Review Form
(Optional)

Last Name_____ First Name_____ MI___MA#_____ SSN/DOB _____

Contact Person_____ Phone_____ Fax_____

Secondary/Surgical diagnoses requiring physician and/or nursing intervention that support the client's need for care in a nursing facility, MADC, Waiver, or PACE_____

_____

Other pertinent findings (e.g., signs/symptoms, complications, lab results, etc.)_____

_____

Has the client been hospitalized in the past three months? ☐ Yes (please provide detail below) ☐ No

Date	Name of Hospital	# Days	Reason/Comments

Diet (include supplements)_____

Height_____ Weight_____ Blood Pressure_____ Have any of the above changed recently? ☐ Yes ☐ No

If yes, please explain_____

_____

Please list all medications that the client currently takes.

Medication	Dosage	Frequency	PRN?	Route	Reason	If PRN, how often given in the past **?

Are any of the above medications new, being frequently adjusted, or are there other problems with them? ☐ Yes (please explain) ☐ No

_____

_____

Please provide any addition information as to why you believe the person's health care needs cannot be safely managed outside a nursing facility, or in the absence of medical adult day care, Waiver, or PACE_____

_____

I certify to the best of my knowledge that the information on this form is correct.

Name of Physician or Nurse (please print or type)_____Signature_____ Date_____

DHMH 4345B
PASRR CATEGORICAL ADVANCE GROUP DETERMINATIONS
EVALUATION REPORT

Name of Individual_____ DOB_____ SSN_____

Admitting Nursing Facility_____Date of Admission_____

Applicable Categorical Advance Group Determination (check all that apply and complete the applicable information):

☐ Provisional admissions in emergency situations not to exceed seven days in cooperation with Adult Protective Services.

Name of APS Contact_____ Jurisdiction_____ Email_____

☐ Respite stays not to exceed 30 days - Anticipated length of stay_____ Reason for respite_____

☐ Severe physical illness – Applicable diagnoses _____

☐ Convalescent care not to exceed 120 days *(Specialized Services referral required)*

Diagnoses for which convalescent care is required_____

☐ Terminal illness (life expectancy of less than 6 months) certified by a physician *(Specialized Services referral required)*

Diagnoses_____Contract hospice _____

If NF does not have a contract with a hospice, has the terminal illness been documented and has the individual waived hospice services?_____

SERVICES TO BE PROVIDED

Modality	Brief Description of Service	Frequency	Anticipated Duration
Physical therapy			
Occupational therapy			
Supportive Mental Health Services (e.g., medication management, referral for evaluation)			
Other therapy/treatment (specify)			

I certify that the foregoing information is true to the best of my knowledge. I also certify that if CAGD is being applied due to the need for convalescent care or terminal illness, the individual has been referred to the local health department Adult Evaluation and Review Services unit for evaluation of the need for Specialized Services.

Signature of Evaluator_____ Date_____

Name of Evaluator (print)_____ Title_____ Phone_____ E-mail_____

Evaluating Source (NF or Hospital)_____

LONG TERM CARE ACTIVITY REPORT (DHMH 257)

□ Community MA □ Waiver

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

TO: Receiving Agency____________________________________

Address ____

____

FROM: Name of Provider _____________________________________

Address____

____

Medicaid Provider ID______________________ CARES Vendor ID_______________________

Contact Name_______________________________ Telephone________________________

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

RECIPIENT INFORMATION

Name ____ Sex □ M □ F Date of Birth ______________

Medicare Claim No. __________________________ MD Medicaid No. _______________________________________

Representative____ Phone______________________________

Address____

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

* *

A. Begin Payment Admission Date____________ Private pay rate__________

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

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

* *

B. Cancel Payment

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

   If discharged to another provider, name of provider ____

2. □ Death – Date of Death ____________________

* *

Administrator/Designee Signature____ Date______________________

Print Name of Administrator/Designee__________________________________ Title__________________________

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

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

□ Chronic/Special Hospital □ Nursing Facility Effective Dates _______________ through________________

_________________________________ _______________________________________ ____________________

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

DHMH 257 (Revised 4/2011)

AGENCY/UCA/PROVIDER COPY

DHMH 2129
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 Rep. Name & UCA Organization)

No. Days approved: _____ **Reason (if different from days requested):** _____

_____

Signature: _____ **Date:** _____

Instructions for Preparation of

REPORT OF ADMINISTRATIVE DAYS – DHMH 2129

A. General: This report is divided into two major sections which are to be completed by the originating nursing facility and certifying utilization control agent (UCA). The source of all information is the patient's record. Detailed instructions for preparation of the form are in the following sections.

B. Nursing Facility:

1. Dates of administrative days requested – Enter the inclusive calendar dates for the period covered by the report. The "from" date will be the day administrative days started if this occurred during the current calendar month. Otherwise, enter the first day of the month. The "through" date will be the day administrative days ended (i.e., the date of death or the day prior to the date of discharge), if this occurred during the current month. Otherwise, enter the last day of the month.

2. Facility name – Enter the full name of the reporting facility and telephone number of the administrator or designee.

3. Resident name – Enter the full name of the patient as it appears on the Medical Assistance (MA) card.

4. Medical Assistance Number – Enter the patient's MA number.

5. Reclassification – Place a check mark on the appropriate line. Enter the effective date of the reclassification.

6. Dates and actions taken – List the dates on which actions were taken to find appropriate placement and briefly describe each action and the outcome. The statements should be descriptive and verifiable to the resident's records. Report only those actions taken during the period covered by this report. A separate sheet may be used if necessary.

7. Administrative days requested: Enter the number of days covered by report.

8. Administrator or designee signature – The administrator or designee must print name and sign the report in order for it to be accepted.

9. Title – Enter the title, within the facility, of the individual signing the report (e.g., Administrator, Social Worker, etc.).

10. Date signed – Enter the date that the report is signed.

C. Utilization Control Agent

The section entitled **UTILIZATION CONTROL AGENT(To be completed by the UCA)** will be completed by the utilization control agent. Please leave it blank.