STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
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MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 191

October 13, 2004

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 transmittal.

RE: Revised Nursing Facility Assessment and Reimbursement Handbook

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Enclosed is a copy of the revised Maryland Medical Assistance Program **Nursing Facility Assessment and Reimbursement Handbook** that replaces the prior edition. Please be certain to share this document with appropriate staff.

The handbook describes the criteria and documentation required for dependency in the five activities of daily living, and for reimbursement for the eight special services, three additional services, three therapy services, hospital and therapeutic leave and administrative days.

This edition includes the revenue codes that are effective with dates of service beginning October 1, 2004. For dates of service prior to October 1, 2004, the four-digit revenue code **and the** 5-digit procedure code must be used as indicated in the Maryland Medicaid UB-92 Billing Instructions for Nursing Facility Services.

Any questions regarding the handbook should be directed to the Division of Long Term Care Services at 410 767-1736.

SJT:seh
Enclosure

cc: Nursing Home Liaison Committee

MARYLAND MEDICAL ASSISTANCE PROGRAM

NURSING FACILITY ASSESSMENT and REIMBURSEMENT HANDBOOK

Issued October 1, 2004

Applicable for Dates of Service beginning October 1, 2004

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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 2.0 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 2.0. The MDS 2.0 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 2.0 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 Staff Specialist 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 (ADL's), 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 ADL's. The ADL's considered in establishing the reimbursement level are:

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

A recipient is considered dependent in an ADL for the entire month if they are determined to be dependent for 15 or more days during the month. 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

1. Communicable Disease Care (revenue code 0239)
2. Central Intravenous Care (revenue code 0269)
3. Peripheral Intravenous Care (revenue code 0260)
4. Decubitus Ulcer Care (revenue codes 0550 and 0272)
5. Tube Feeding
    a. Medicare (revenue code 0559)
    b. Medicaid only (revenue codes 0559 and 0279)
6. Ventilator Care (revenue code 0419)
7. Support Surface A (revenue code 0290)
8. Support Surface B (revenue code 0299)

B. Additional Services

1. Oxygen/Aerosol Therapy (revenue code 0412)
2. Suctioning/Tracheostomy Care (revenue code 0410)
3. Turning and Positioning (revenue code 0230)

C. Therapy Services

1. Physical Therapy (revenue code 0420)
2. Occupational Therapy (revenue code 0430)
3. Speech Therapy (revenue code 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. Therapeutic home leave - 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 2.0, or MDS 2.0. The entire MDS 2.0 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 will be required to update the information in the sections listed below on a monthly basis. Facilities are directed to complete the Maryland Monthly Assessment in accordance with MDS 2.0 instructions. Information on the recipient's functioning during the period requested in the MDS 2.0 (7-14 days) will be considered to reflect the recipient's functioning during the majority of the month. The following MDS 2.0 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 2.0 as used in Key Documentation sections may refer to either the annual MDS 2.0 or the intervening supplement (Maryland Monthly Assessment). The sections are as follows:

G. Physical Functioning and Structural Problems - "Self Performance" and "Support" columns on MDS 2.0; "Self Performance " only on Maryland Monthly Assessment

H. Continence in the Last 14 Days

J. Health Conditions

K. Oral/Nutritional Status

M. Skin Condition

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, Minimum Data Set Version 2.0, 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

documenting periodic review of the recipient's status and the recipient's treatment plan, unless an alternative schedule for physician's visits is employed in accordance with COMAR 10.07.02. 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. 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 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.

MDS 2.0 Section G Physical Functioning and Structural Problems

			Self Performance	Support
Dependent:				
Item:		b. Transfer	2, 3 or 4	2 or 3
Bed Chair confined:				
Items:	1	a. Bed Mobility	4	2 or 3
		b. Transfer	4	2 or 3
		c. Walk in Room	8	8
		d. Walk in Corridor	8	8
		e. Locomotion on Unit	0[1], 4 or 8	2, 3 or 8
		f. Locomotion Off Unit	0[1], 4 or 8	2, 3 or 8
		G. 5c Other person wheeled		checked
		G. 6 a, c or d		checked

MDS 2.0 Section M. Skin Condition

Item 5c turning/repositioning program

[1]If the recipient uses a motorized wheelchair, coding under "Locomotion on/off unit", may be "0", and recipient may be described as "wheeled self". 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.

MDS 2.0 Section G Physical Functioning and Structural Problems

	Self Performance	Support
Item 2 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 2.0 Section G Physical Functioning and Structural Problems

		Self Performance	Support
Item	1g 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.

[2] A 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.

	Self Performance	Support
MDS 2.0 - Section G.		
Item I	3 or 4	2 or 3

MDS 2.0 - Section H Continence in Last 14 Days

Item			Self Performance
Item	1a	bowel continence	0[1] 3 or 4
	1b	bladder continence	0[2] 3 or 4
	3	appliances and programs	checked, a, b, c, d, g, I

[1]If a "0" code is used for item 1a, item 3i (ostomy) must be checked, and Section G must be coded as shown above.

[2]If a "0" code is used for item 1b, and 3 c or d (catheter) is checked, then the recipient will be considered dependent in continence.

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.

MDS 2.0 Section G Physical Functioning and Structural Problems

	Self Performance	Support
Item 1h	Eating 1[1],2, 3 or 4	2 or 3

MDS 2.0 Section K Oral/Nutritional Status

Item		
1b	Swallowing problem	checked
5b	Feeding tube	checked
6a) 1, 2, 3 or 4	Parenteral or Enteral Intake	
6b) 1, 2 , 3 , 4 or 5		

[1]When 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.
3. The provider shall complete the Request for Reimbursement for Bed Reservations During Acute Hospitalization (DHMH 1321). A copy of this form must be retained in the medical record.
4. 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. Nursing Facility Request for Reimbursement for Bed Reservations During Acute Hospitalization (DHMH 1321).
2. Physician's order for acute hospitalization. The order must be specific as to admitting hospital, date and purpose for admission.

II. THERAPEUTIC HOME LEAVE (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 therapeutic home leave, the recipient's plan of care must provide for the absence.
3. The provider shall complete the Authorization for Leave of Absence (DHMH 1295). A copy of this form must be retained in the medical record.
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 therapeutic leave day, even though the recipient does not remain out overnight.

KEY DOCUMENTATION

1. Authorization for Leave of Absence (DHMH 1295).
2. 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.

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 discharge 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, 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 2.0.

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.
3. MDS 2.0 Section K - Oral Nutritional Status. Item 5a Parenteral/IV checked.

IV. DECUBITUS ULCER CARE (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. 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 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 soft tissue. 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 "tunneling" in which the area forms deep, narrow tunnels into the surrounding tissue.

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 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: Note: Each reimbursable day of care will be a composite of revenue code 0550, skilled nursing - general and revenue code 0272, medical/surgical supplies - sterile.

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 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.

2. MDS 2.0 Section M - Skin Condition

		Code	
Item 1	Ulcers	c or d	document the number of ulcers present at Stage 3 and/or 4
Item 5c	Turning/repositioning program	checked	

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.

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 2.0 Section K Oral Nutritional Status
   Item 5b feeding tube checked
2. Physician's Orders
3. Treatment and/or Medication Sheets must indicate performance and be signed by the licensed medical professional providing the care.
4. If recipient is tube fed, MDS 2.0 - Section G item 1h Self Performance must be coded "4".

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 O_2 /Aerosol therapy and Suctioning/Tracheostomy care as applicable.
4. Other supporting documentation as necessary.

VII. <u>SUPPORT SURFACE A</u> (0290)

<u>Item Definition:</u> 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.

<u>NOTE:</u> In order to be reimbursable under this service, <u>all</u> of the following requirements <u>must</u> 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 <u>Decubitus Ulcer Care</u>).

   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 of patient;
   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 of the recipient; 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 <u>Handbook</u>, 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 2.0 Section G Physical Functioning and Structural Problems 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.

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 therapist[1];
   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,

[1] A "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.

of the need for and appropriateness of physical therapy services in the same manner it 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 therapist[1];
   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

[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.

therapist, of the need for and appropriateness of occupational therapy in the same manner it 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 pathologist[1];
   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

[1] A "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.

language pathologist, of the need for and appropriateness of speech therapy in the same manner it 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

Maryland Monthly Assessment

Resident ______________________ Room __________ Numeric Identifier __________

Year __________ Day/Month ➡

No.	Item	Description	Code	/	/	/	/	/	/	/	/	/	/	/	/
SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS															
1a.	BED MOBILITY	How resident moves to/from lying position, turns side to side, positions body while in bed.	A												
1b.	TRANSFER	How resident moves between surfaces—to/from bed/chair/wheelchair/standing position	A												
1c.	WALK IN ROOM	How resident walks between locations in room	A												
1d.	WALK IN CORRIDOR	How resident walks in corridor on unit.	A												
1e.	LOCOMOTION ON UNIT	How resident moves between locations in room and adjacent corridor on same floor	A												
1f.	LOCOMOTION OFF UNIT	How resident moves to, returns from off-unit locations.	A												
1g.	DRESSING	How resident puts on/fastens/takes off all items of street clothing, including donning/removing prosthesis.	A												
1h.	EATING	How resident eats/drinks (regardless of skill).	A												
1i.	TOILET USE	How resident uses toilet room; transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.	A												
2.	BATHING	How resident takes full-body bath/shower, sponge bath, transfers in/out of tub/shower.	A												
5.	MODES OF LOCOMOTION	*Check all that apply.*													
		b. Wheeled self	b												
		c. Other person wheeled	c												
6.	MODES OF TRANSFER	*Check all that apply during last 7 days.*													
		a. Bedfast all or most of time	a												
		b. Bed rails used for bed mobility or transfer	b												
		c. Lifted manually	c												
		d. Lifted mechanically	d												
SECTION H. CONTINENCE IN LAST 14 DAYS															
1a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed.													
1b.	BLADDER CONTINENCE	Control of urinary bladder function with appliances (e.g., foley) or continence programs, if employed													
3.	APPLIANCES & PROGRAMS														
		a. Any scheduled toileting plan	a												
		b. Bladder retraining program	b												
		c. External (condom) catheter	c												
		d. Indwelling catheter	d												
		i. Ostomy present	i												
		j. NONE OF ABOVE	j												
SECTION K. ORAL/NUTRITIONAL STATUS															
2.	WEIGHT	b. Record weight in pounds.													
5.	NUTRITIONAL APPROACHES														
		a. Parenteral IV	a												
		b. Feeding tube	b												
		d. Syringe oral feeding	d												
6.	PARENTERAL OR ENTERAL INTAKE	a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 1. 1% to 25% 2. 26% to 50% 3. 51% to 75% 4. 76% to 100%													
		b. Code the average fluid intake per day by IV or tube in last 7 days 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day													
SECTION M. SKIN CONDITION															
1.	ULCERS (due to any cause)	*Record the number of ulcers at each stage regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more. Requires full body exam*													
		a. Stage 1	a												
		b. Stage 2	b												
		c. Stage 3	c												
		d. Stage 4	d												

Resident ______ Room ______ Numeric Identifier ______

Year ______ Day/Month →

SECTION M. SKIN CONDITION (Cont'd)

2.	ULCER TYPE	*For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1, i.e., 0 – none; stages: 1, 2, 3, 4*	
		a. Pressure ulcer	a
		b. Stasis ulcer	b
5.	SKIN TREATMENT	a. Pressure-relieving device for chair	a
		b. Pressure-relieving device for bed	b
		c. T/P program	c
		d. Nutrition/hydration	d
		e. Ulcer care	e
		f. Surgical wound care	f

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

4.	DEVICES & RESTRAINTS	a. Full bed rails on all open sides of bed	a
		b. Other types of side rails used (e.g., half rail, one side)	b
		c. Trunk restraint	c
		d. Limb restraint	d
		e. Chair prevents rising	e

SIGNATURE OF PERSON(S) COMPLETING FORM:

Signature ______ Date ______ Signature ______ Date ______

Signature ______ Date ______ Signature ______ Date ______

Signature ______ Date ______ Signature ______ Date ______

Signature ______ Date ______ Signature ______ Date ______

Signature ______ Date ______ Signature ______ Date ______

Signature ______ Date ______ Signature ______ Date ______

FOOTNOTES: (Include Date, Section/Footnote/Initials)

MARYLAND MEDICAL ASSISTANCE PROGRAM

AUTHORIZATION FOR LEAVE OF ABSENCE

Nursing Facility: ______________________ Provider Number: ______________________

Name of Patient: ______________________ Medical Assistance Number: ______________

Period for which reimbursement for bed reservation is requested:

A. ____ (Actual date patient
Month Day Year leaves nursing home)

B. ____ (Actual date patient
Month Day Year returns to nursing home)

C. Number of Days: ______________ (Do not count date of return)

By: ______________________________
Facility Administrator or Designee

I hereby certify that: (1) I am the patient's attending physician and (2) leave of absence(s) are a recorded part of this patient's therapeutic plan of treatment on file in the above facility.

______________ By: ______________________________
Date Physician must sign here

DHMH 1295 (Rev. 7/88)

MARYLAND MEDICAL ASSISTANCE PROGRAM

NURSING FACILITY REQUEST FOR REIMBURSEMENT FOR BED RESERVATIONS DURING ACUTE HOSPITALIZATION

1. Nursing Facility:____________________
2. Name of Hospital:____________________
3. Date of Hospital Admission:____________________
4. Name of Patient:____________________
5. Medical Assistance #:____________________

Part A

I hereby certify that (1) I am the patient's attending physician, (2) the recommended period of hospitalization is medically necessary as a result of an acute condition, and (3) the period of hospital confinement is not expected to exceed 15 days.

By:______________________________

I hereby certify that the____________________Nursing Facility guarantees that upon return from the hospital, the patient's bed will be available, if medically appropriate, anytime within 16 days from the date of admission to the hospital.

By:______________________________

Nursing Facility Authorized Signature Date

Part B

To be completed when patient returns from acute hospital or stays longer than 15 days.

1. If discharged from hospital, date patient returned to nursing home.

____

Month Day Year

2. If patient remains in hospital longer than 15 days, date of 16th day after admission to hospital.

____

Month Day Year

3. If deceased, date of death.

____

Month Day Year

4. If patient must be discharged from nursing home during bed reservation period due to level of care changes, enter the date of discharge.

____

Month Day Year

5. Other (enter reason) ______________________________
Enter date of discharge from nursing home.

____

Month Day Year

6. Number of days claimed____________________(not to exceed 15 days).

I hereby certify that the above information is true and correct and subject to P.S.R.O. certification.

By:______________________________

Nursing Facility Authorized Signature Date

DHMH 1321 (Rev. 7/88)

Instructions for Preparation of

REPORT OF ADMINISTRATIVE DAYS IN LONG TERM CARE FACILITIES

A. General: This report is divided into two major sections which are to be completed by the originating Long-Term Care (LTC) Facility and the certifying PSRO. The source of all information is the patient's record. Detailed instructions for preparation of the form are in the following sections. Refer to the appropriate guideline for report due date, distribution, and overall paper flow.

B. Long-Term Care Facility

1. Reporting Period: - 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 "to" date will be the day Administrative Days ended, 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.

3. Patient Name: - enter the full name of the patient as it appears on the Medical Assistance (MA) card.

4. Medical Assistant Number: - Enter, in the spaces provided, the patient's MA number.

5. Reclassified From: ☐ Skilled ☐ ICF - A to ☐ ICF - A ☐ ICF - B on ____________________, 20 _____:

   - Place a check mark in the appropriate "From" and "To" boxes. Enter the effective date of the reclassification.

6. List the dates action was taken to find appropriate placement and briefly describe each: - The statements should be descriptive and verifiable to the Patient's Chart. Report only those actions taken during the period covered by this report. A separate sheet may be used if necessary.

7. Administrative Days: - Enter the number of days covered by this report.

8. Waiver Statement: - This section is applicable to multi-level facilities only. It is required in order for the Department to waive certain limitations on Administrative Days. Refer to appropriate guidelines and regulations for specific requirements.

9. Administrator or Designee Signature: - The Administrator or his Designee must sign the report. In order for it to be accepted.

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

11. Date Signed: - Enter the date that the report is signed.

C. PSRO Certification

1. PSRO Name: - Enter the full name of the PSRO.

2. _____ Days Approved: - Enter the number of Administrative Days being approved. If this number is not the same as those shown above, indicate the reason in the space provided.

3. _____ Days Disapproved: - Enter the number of days disapproved and show the reason for disapproval.

4. Signature: and Date: - The person authorized by the PSRO will sign the certification and enter the date signed.

Department of Health and Mental Hygiene

Medical Care Programs

Medical Assistance Compliance Administration

REPORT OF ADMINISTRATIVE DAYS IN LONG-TERM CARE FACILITIES

Reporting Period: From ____________________, 20 _____ through ____________________, 20 _____

Facility Name: ____

Patient Name: ____

Medical Assistance Number: ☐☐ ☐☐☐☐☐☐☐ ☐☐

Reclassified From: ☐ Skilled ☐ ICF - A to ☐ ICF - A ☐ ICF - B on ____________________, 20 _____

List the dates action was taken to find appropriate placement and briefly describe each.

Date	Action Taken

Administrative Days: ____________________

WAIVER STATEMENT (Multi-Level Facilities Only)

We ☐ will, ☐ will not place this patient in the first appropriate bed available within this facility.

Administrator or Designee Signature: ____________________ Title: ____________________

Date Signed: ____________________

PSRO CERTIFICATION

PSRO Name: ____

_____ Days Approved, Reason (If Different From Reported Days): ____________________

_____ Days Disapproved, Reason: ____________________

Signature: ____________________ Date: ____________________

DHMH 2129 (Revised 4/2003)

TREATMENT RECORD and TREATMENT FREQUENCY (in minutes)

*Record date of each therapy session; initial treatment modality provided; minutes per modality per day; total minutes of therapy per treatment date; record final total minutes of therapy provided.

Patient Name ____________________ **Month** __________ **Year** ______

TREATMENT MODALITIES	1	2	3	4	5	6	1	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total Minutes
Total Minutes																																

Therapist ____________ Initials ______ Therapist ____________ Initials ______

Therapist ____________ Initials ______ Therapist ____________ Initials ______

Therapist ____________ Initials ______ Therapist ____________ Initials ______

Therapist ____________ Initials ______ Therapist ____________ Initials ______

Rev. 10/97
TREATMEN.CHT

PATIENT ASSESSMENT RECONSIDERATION

Following the onsite assessment, but before payment adjustments are made, the Agent provides each facility with a hard copy of the assessment form 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 Minimum Data Set (MDS) or the Monthly Assessment form for the month in question and the two prior months;

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.

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.

MARYLAND MEDICAID
UB-92 BILLING INSTRUCTIONS
(as edited 10/13/04)

NURSING FACILITY SERVICES

EFFECTIVE OCTOBER 17, 2004

THESE INSTRUCTIONS ARE FOR PAPER CLAIMS ONLY.

Additional fields will be required for electronic billing. For information on electronic billing, please refer to the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional 837.

BILLING TIME LIMITATIONS

Invoices must be received within nine (9) months of the month of service on the invoice. If a claim is received within the 9-month limit but rejected, resubmission will be accepted within 60 days of the date of rejection or within 9 months of the month of service, whichever is longer. If a claim is rejected because of late receipt, the patient may not be billed for that claim. If a claim is submitted and neither a payment nor a rejection is received within 90 days, the claim should be resubmitted.

OTHER THIRD-PARTY RESOURCES

All other third-party resources should be billed first and payment either received or denied before the Medical Assistance Program may be billed for any portion not covered. However, if necessary to meet the 9-month deadline for receipt of the claim(s), the Medical Assistance Program may be billed first and then reimbursed if the third-party payer makes payment later.

It is preferred that invoices be typed. If printed, the entries must be legible and in black or blue ink only. Do not use pencil or a red pen to complete the invoice. Otherwise, payment may be delayed or the claim rejected. The instructions which follow are keyed to the form locator number and headings on the UB-92 form.

Completed invoices are to be mailed to the following address:

Maryland Medical Assistance Program
Division of Claims Processing
P.O. Box 1935
Baltimore, MD 21203

REQUIRED FIELDS HAVE FIELD NUMBER AND NAME BOLDED & UNDERLINED

FL 1 **(Untitled)**

Provider name, address, zip code, and telephone number.

Line 1 - Enter the provider name filed with the Medical Assistance Program.

Line 2 & 3 - Enter the address to which the invoice should be returned if it is rejected due to provider error.

NOTE: Checks and remittance advices are sent to the provider's address as it appears in the Program's provider master file.

Line 4 - Enter provider area code and phone number (optional).

FL 2 (Untitled)
DO NOT USE. This field has been assigned by Maryland Medicaid for internal use only. (ICN- Invoice Control Number)

FL 3 **Patient Control Number**

Enter the patient's control number assigned to the patient by the facility. A maximum of 11 positions will be returned on the remittance advice to the provider. The facility must assign each patient a unique number.

FL 4 **Type of Bill**

This three-digit numeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third digit indicates the bill sequence for this particular episode of care and is referred to as a "frequency" code. All three digits are required to process a claim.

CODE STRUCTURE

Type of Facility	(1st digit)
Bill Classification	(2nd digit)
Frequency	(3rd digit)

Type of Facility	**1st Digit**
Skilled Nursing	2
Type of Care	**2nd Digit**
Intermediate Care	6
Frequency	**3rd Digit**
Admit Through Discharge Claims	1

Interim Billing - First Claim	2
Interim Billing- Continuing Claim	3
Interim Billing - Last Claim	4

DEFINITIONS FOR FREQUENCY

(1) - Admit Through Discharge Claims

This code is to be used when a bill is expected to be the only bill to be received for a course of treatment. This will include bills representing a total course of treatment, and bills which represent an entire benefit period of the primary third party payer.

(2) - Interim Billing - First Claim

This code is to be used for the first of a series of bills to the same third party payer for the same course of treatment. If used, Locator 22 should equal "30".

(3) - Interim - Continuing Claim

This code is to be used when a bill for the same course of treatment has previously been submitted and it is expected that further bills for the same course of treatment will be submitted. If used, Locator 22 should equal "30".

(4) - Interim - Last Claim

This code is to be used for the last of a series of bills for which payment is expected to the same third party payer for the same course of treatment.

FL 5 Federal Tax No.
Not required

FL 6 Statement Covers Period (From - Through)

Enter the "From" and "Through" dates covered by the services on the invoice (MMDDYY).

NOTE: Medicare Part A and Part B claims should include the from and through dates as indicated on the Medicare payment listing or EOMB. Statement covers period dates must match the dates reflected on the Medicare EOMB.

FL 7 Covered Days

Number of days covered by invoice

FL 8 Non-covered Days
Not required

FL 9 Co-insurance Days
Not required

FL 10 Lifetime Reserve Days
Not required

FL 11 Untitled
Not required

FL 12 **Patient Name**

Enter the patient's name as it appears on the Medical Assistance card: last name, first name, and middle initial. (Please print this information clearly.)

FL 13 Patient Address
Not required

FL 14 Patient Birth Date
Not required

FL 15 Patient Sex
Not required

FL 16 Patient Marital Status
Not required

FL 17 **Admission/Start of Care Date** **(Required 1st month only)**

Enter the Facility Admission Date

NOTE: When a nursing home patient goes into hospice and returns to the nursing home the old admittance date to the nursing home is acceptable for the new admittance date from hospice care.

FL 18 Admission Hour
Not required

FL 19 **Type of Admission**

Enter Code 3 – Elective

FL 20 **Source of Admission**

Enter appropriate code from table below:

1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a hospital
5	Transfer from a skilled nursing facility
6	Transfer from another health care facility (other than acute care or skilled nursing facility)
7	Emergency Room

8	Court/Law Enforcement

FL 21 Discharge Hour
Not required

FL 22 **Patient Status**

Enter appropriate code from list below indicating the patient's disposition at the time of billing for that period of care.

01	Discharged to self or home care
02	Discharged/transferred to a short term general hospital for inpatient care
03	Discharged/transferred to a skilled nursing facility (SNF)
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another institution for inpatient care or referred for outpatient services to another institution
06	Discharged/transferred to home under care of an organized home health service organization
07	Left against medical advice or discontinued care
20	Expired
30	Still a patient
43	Discharged/transferred to a federal hospital
50	Hospice – home (discharged to)
51	Hospice – medical facility (discharged to)

FL 23 Medical Record Number
Not required

FL 24-30 Condition Codes
Not required

FL 31 Untitled
Not required

FL 32-35 a-b **Occurrence Codes and Dates**

Use these codes if applicable. Enter the appropriate codes and dates from the codes listed below. Fields 32a-35a must be completed before fields 32b-35b can be utilized. If all the occurrence code fields 32a & b – 35a & b are filled, then 36a & b may be used to capture additional occurrence codes. When FL 36 is used in this way the "through" date is left blank.

Code 25 replaces the third party liability "K" override code.

Code	Definition
42	Date of Death/Discharge
25	Date Benefits Terminated by Primary Provider
A3	Benefits Exhausted (This code is used when Medicare benefits are exhausted)

FL 36a &b **Occurrence Span Codes and Dates**

Required for Administrative Days if any are billed.

Enter an occurrence code and span for Administrative Days. The Administrative Day occurrence Code is 75. Therefore, in FL36 enter 75 under code, and the span covered under FROM and THROUGH. These days **must** be billed under the Administrative Day Revenue Code, 0169, in FL42.

Administrative Day span data will be given to Delmarva along with the other data they receive from the monthly claim as part of the patient assessment process. Delmarva will check to see if documentation for Administrative Days exists for the days entered on the claim. If the documentation for Administrative Days does not exist or is not acceptable, the days will be denied.

Providers will no longer be required to attach a copy of the DHMH 2129 to the invoice.

FL 37 Internal Control Number (ICN)/Document Control Number (DCN)
Not required

FL 38 Untitled
Not required

FL 39-41 a-b Value Codes and Amounts
Not required

FL 42 **Revenue Codes**

FOR SERVICE DATES PRIOR TO OCTOBER 1, 2004

Enter **both** the 5-digit procedure code **in FL 44** **and** the four-digit revenue code **in FL 42** from the chart below that crosswalks procedure codes to revenue codes. After the last set of codes, enter revenue code 0001 – Total Charge.

NOTE:

1. For therapy services, link the specific procedure code with the more generic revenue code, e.g. procedure codes N0200, N0205, N0210 and N0215 would all be linked to revenue code 0420.

2. For services that link one procedure code to 2 revenue codes (one for associated supplies), tube feeding Medicaid and decubitus ulcer care, link the procedure code to the one revenue code for skilled nursing as indicated in the pre-October service date chart. The supply revenue codes for these procedures have been omitted.
3. Regarding administrative days, for pre-October services bill the level of care procedure code and the corresponding level of care revenue code.

4. **For services eliminated as of July 1, 2003**: Days of Care Light Behav, Days of Care Moderate Behav, Ostomy Care, Single Injections and Multiple Injections link the

procedure code to the temporary revenue code as indicated in the pre-October service date chart under the Section "Eliminated Services".

PRE - OCTOBER 2004 SERVICE DATE CHART

PROCED CODES – FL 44		REVENUE CODES – FL 42		
DESCRIPTION	**PROCED CODE**	**DESCRIPTION**	**REVENUE CODE**	**UNITS**
DAYS OF CARE				
Days of Care Light	N0010	Rm & Brd Semi-Private – General	**0120**	
Days of Care Moderate	N0020	Rm & Brd Semi-Private – Other	**0129**	
Days of Care Heavy	N0030	Subacute Care-General	**0190**	
Days of Care Heavy Spec	N0040	Subacute Care-Other	**0199**	
ICF - MR	N2200	All Inclusive Rm & Brd Plus Ancillary	**0100**	
Hospital Leave	N0005	Leave of Absence – NH-Hospital	**0185**	
Therapeutic Home Leave	N0006	Leave of Absence – Therapeutic Lv.	**0183**	
Coinsurance Days	N0120	All Inclusive Rm & Brd	**0101**	
Administrative Day	Most recent level	Administrative Day	**Most recent level**	
ADDITIONAL NURSING SERVICES				
Class A Support Surface	N0051	DME – General	**0290**	
Class B Support Surface	N0052	DME – Other	**0299**	
Oxygen	N0090	Respiratory – Inhalation Services	**0412**	
Suctioning/Trache Care	N0110	Respiratory – General	**0410**	
Ventilator Care	N0115	Respiratory – Other	**0419**	
IV - Central Line	N0048	IV Therapy – Other	**0269**	
Peripheral IV	N0100	IV Therapy – General	**0260**	
Turning and Positioning	N0043	Incremental Nursing – General	**0230**	
Communicable Disease Care	N0046	Incremental Nursing – Other	**0239**	
Tube Feeding Medicaid	N0044	Skilled Nursing – Other	**0559**	
Tube Feeding - Medicare	N0045	Skilled Nursing – Other	**0559**	
Decubitus Ulcer Care	N0042	Skilled Nursing – General	**0550**	
ELIMINATED SERVICES				
Days of Care Light Behav	N0015		**0124**	
Days of Care Moderate Behav	N0025		**0194**	
Ostomy	N0080		**0670**	
Single Injections	N0060		**0680**	
Multiple Injections	N0070		**0690**	
THERAPY SERVICES				
Physical Therapy 1/4 hour	N0200	Physical Therapy – General	**0420**	1 unit per day
Physical Therapy 1/2 hour	N0205	Physical Therapy – General	**0420**	2 units per day
Physical Therapy 3/4 hour	N0210	Physical Therapy – General	**0420**	3 units per day
Physical Therapy 1 hour	N0215	Physical Therapy – General	**0420**	4 units per day
Occupational Therapy 1/4 hour	N0300	Occupational Therapy – General	**0430**	1 unit per day
Occupational Therapy 1/2 hour	N0305	Occupational Therapy – General	**0430**	2 units per day
Occupational Therapy 3/4 hour	N0310	Occupational Therapy – General	**0430**	3 units per day
Occupational Therapy 1 hour	N0315	Occupational Therapy – General	**0430**	4 units per day

Speech Therapy 1/4 hour	N0400	Speech Therapy – General	0440	1 unit per day
Speech Therapy 1/2 hour	N0405	Speech Therapy – General	0440	2 units per day
Speech Therapy 3/4 hour	N0410	Speech Therapy – General	0440	3 units per day
Speech Therapy 1 hour	N0415	Speech Therapy – General	0440	4 units per day

FOR SERVICE DATES BEGINNING OCTOBER 1, 2004

Enter the appropriate four-digit revenue code **only in FL 42** from the chart below that crosswalks procedure codes to revenue codes. Please note that there are **two revenue codes** for Tube Feeding Medicaid and Decubitus Ulcer Care. After the last code, enter revenue code 0001 – Total Charge. To assist in bill review, revenue codes should be listed in ascending numeric sequence with the exception of "0001 - Total Charge" which should always be last.

NOTE: Each revenue code may only be used once. Consolidate all charges and units into one revenue code line item. For example, enter only one code for Physical Therapy.

SERVICE DATES BEGINNING OCTOBER 1, 2004 CHART

PROCED CODES - do not use		REVENUE CODES - FL 42		
DESCRIPTION	**PROCED CODE**	**DESCRIPTION**	**REVENUE CODE**	**UNITS**
DAYS OF CARE				
Days of Care Light	N0010	Rm & Brd Semi-Private - General	0120	
Days of Care Moderate	N0020	Rm & Brd Semi-Private - Other	0129	
Days of Care Heavy	N0030	Subacute Care-General	0190	
Days of Care Heavy Spec	N0040	Subacute Care-Other	0199	
ICF - MR	N2200	All Inclusive Rm & Brd Plus Ancillary	0100	
Hospital Leave	N0005	Leave of Absence – NH-Hospital	0185	
Therapeutic Home Leave	N0006	Leave of Absence – Therapeutic Lv.	0183	
Coinsurance Days	N0120	All Inclusive Rm & Brd	0101	
Administrative Day	Most recent level	Administrative Day	0169 with code 75 and span in FL36	
ADDITIONAL NURSING SERVICES				
Class A Support Surface	N0051	DME – General	0290	
Class B Support Surface	N0052	DME – Other	0299	
Oxygen	N0090	Respiratory – Inhalation Services	0412	
Suctioning/Trache Care	N0110	Respiratory – General	0410	
Ventilator Care	N0115	Respiratory – Other	0419	
IV - Central Line	N0048	IV Therapy – Other	0269	
Peripheral IV	N0100	IV Therapy – General	0260	
Turning and Positioning	N0043	Incremental Nursing – General	0230	
Communicable Disease Care	N0046	Incremental Nursing – Other	0239	
Tube Feeding Medicaid **(note that this procedure crosswalks to 2 revenue codes)**	N0044	Skilled Nursing – Other Medical/Surgical Supplies - Other	0559 0279	

Tube Feeding - Medicare	N0045	Skilled Nursing – Other	**0559**	
Decubitus Ulcer Care **(note that this procedure crosswalks to 2 revenue codes)**	N0042	Skilled Nursing – General Medical/Surgical Supplies - Sterile	**0550** **0272**	
THERAPY SERVICES				
Physical Therapy 1/4 hour	N0200	Physical Therapy – General	**0420**	1 unit per day
Physical Therapy 1/2 hour	N0205	Physical Therapy – General	**0420**	2 units per day
Physical Therapy 3/4 hour	N0210	Physical Therapy – General	**0420**	3 units per day
Physical Therapy 1 hour	N0215	Physical Therapy – General	**0420**	4 units per day
Occupational Therapy 1/4 hour	N0300	Occupational Therapy - General	**0430**	1 unit per day
Occupational Therapy 1/2 hour	N0305	Occupational Therapy - General	**0430**	2 units per day
Occupational Therapy 3/4 hour	N0310	Occupational Therapy - General	**0430**	3 units per day
Occupational Therapy 1 hour	N0315	Occupational Therapy - General	**0430**	4 units per day
Speech Therapy 1/4 hour	N0400	Speech Therapy – General	**0440**	1 unit per day
Speech Therapy 1/2 hour	N0405	Speech Therapy – General	**0440**	2 units per day
Speech Therapy 3/4 hour	N0410	Speech Therapy – General	**0440**	3 units per day
Speech Therapy 1 hour	N0415	Speech Therapy – General	**0440**	4 units per day

FL 43 Revenue Descriptions
Not required

FL 44 HCPCS/RATES

Required for dates of service prior to 10/1/04 only.
Enter the 5 digit procedure code from the pre – October 2004 service date chart

FL 45 Service Date
Not required

FL 46 Units of Service

Enter the number of days or units of service on the line adjacent to the revenue code. There must be days or units of service for every revenue code except 0001.

Up to three numeric digits may be entered.

NOTE:

For Service Dates Prior to October 1st

1. The days of care will be linked to **procedure codes and revenue codes** as indicated in the pre-October service date instructions and chart.

2. Enter the **days** associated with the **therapy procedure codes.**

For Service Dates Beginning October 1st

1. **Sum the units** for the therapy **revenue codes.**

FL 47 Total Charges

Using Medical Assistance reimbursement rates, sum the total covered charges for the billing period by revenue code (FL 42) and enter them on the adjacent line in FL 47.

NOTE: Medical Assistance will pay the lower of Medical Assistance rates or the billed rates, if different.

The last revenue code entered in FL 42 is 0001 which represents the grand total of all charges billed. Sum column 47 on the adjacent line. Each line allows up to nine numeric digits (0,000,000.00).

FL 48 — Non-Covered Charges
Not required

FL 49 — Untitled
Not required

FL 50 a,b,c — Payer Identification
Not required

FL 51 a,b,c — Medical Assistance Provider Number

Enter the 9-digit provider number assigned by the Medical Assistance Program.

NOTE: If other provider numbers are listed, then the Medical Assistance provider number should be the last entry in this field.

FL 52 a,b,c — Release of Information Certification Indicator
Not required

FL 53 a,b,c — Assignment of Benefits Certification Indicator
Not required

FL 54 a,b,c — Prior Payments - Payer and Patients

Enter the amount paid by any third-party insurer. These amounts should be entered on lines a,b,or c according to payer in FL 50

NOTE: Do not report Medicare's payment in this field.

FL 55 a,b,c — Estimated Amount Due
Not required

FL 56 — Untitled
Not required

FL 57 — Untitled
Not required

FL 58 a,b,c — Insured's Name
Not required

FL 59 a,b,c — Patient Relationship to Insured
Not required

FL 60 — **Certificate/SSN/HIC/ID Number**

Enter the Medical Assistance number of the insured as it appears on the Medical Assistance card.

REMINDER: Providers may verify a patient's current Medical Assistance eligibility by calling the Eligibility Verification Services (EVS) line:

Baltimore Metropolitan Area:	(410) 333-3020
Toll-Free Long Distance:	1-800-492-2134

If the patient does not have his or her Medical Assistance identification card, a provider may call (410) 767-5503, or 1-800-445-1159, identify themselves by provider number, give the patient's full name, address, social security number, and date of birth and obtain the Medical Assistance number.

FL 61 — Insured's Group Name
Not required

FL 62 — Insurance Group Number
Not required

FL 63 — Treatment Authorization Codes
Not required

FL 64 a,b,c — Employment Status Code
Not required

FL 65 — Employer Name
Not required

FL 66 — Employer Location
Not required

FL 67 — **Principal Diagnosis Code**

Enter the full ICD-9-CM code describing the principal diagnosis.

Always code to the most specific level possible, but do not enter any decimal points when recording codes on the UB-92.

FL's 68-75 — Other Diagnosis Codes
Not required

FL 76 — Admitting Diagnosis
Not required

FL 77 External Cause of Injury Code (E-Code)
Not required

FL 78 Untitled
Not required

FL 79 Procedure Coding Method Used
Not required

FL 80 Principal Procedure Code and Date
Not required

FL 81 a-e Other Procedure Codes and Dates
Not required

FL 82 Attending Physician Identification Number

Enter the 9-digit Medical Assistance provider number of the patient's attending physician. If the attending physician has a Medical Assistance provider number but it is not known/available, enter "999995700".

FL 83 Other Physician Identification Number
Not required

FL 84 Remarks
Not required

FL 85 Provider Representative Signature
Not required

FL 86 Date Bill Submitted

Complete this field with the 6-digit date billed.