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

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 243
October 2, 2012

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.

SUBJECT: Modifications to Reimbursement Handbook

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The purpose of this transmittal is to convey the following modifications to the *Maryland Medical Assistance Program's Nursing Facility Assessment and Reimbursement Handbook*:

1. The inclusion of Intensive Tracheostomy Care as a special service beginning July 1, 2012. Under this service, the Program will make payment at an increased reimbursement rate for tracheostomy care that meets the requirements outlined in the Handbook;

2. Removal of Communicable Disease Care as a covered ancillary service as of July 1, 2012;

3. Removal of Hospital Leave as a covered service for hospitalization dates on or after July 1, 2012;

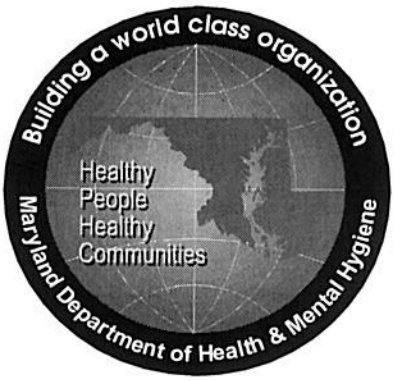
4. Clarification of the requirement for reimbursement at the Heavy Special rate. A recipient is classified as heavy special care if dependent in all five activities of daily living and receiving at least one special service for more than 50 percent of the care days reimbursed by Maryland Medicaid in that calendar month.

The Handbook pages affected by the Program changes are attached. Please include these new pages and remove old pages as needed. Any questions regarding this transmittal may be directed to the Nursing Home Program at (410) 767-1736.

cc: Nursing Home Liaison Committee
Utilization Control Agent

Attachment

DEPARTMENT OF HEALTH AND MENTAL HYGIENE



MARYLAND MEDICAL ASSISTANCE PROGRAM

NURSING FACILITY ASSESSMENT and REIMBURSEMENT HANDBOOK

Issued October 1, 2010
Updated July 1, 2012

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II. REIMBURSEMENT LEVELS AND ANCILLARY SERVICES

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

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

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

Light (revenue code 0120)	Dependent in 0, 1 or 2 ADLs
Moderate (revenue code 0129)	Dependent in 3 or 4 ADLs
Heavy (revenue code 0190)	Dependent in all 5 ADLs
Heavy Special (revenue code 0199) Dependent in all 5 ADLs **AND** requires and receives one or more of: Central Intravenous Line, Peripheral Intravenous Care, Decubitus Ulcer Care, Tube Feeding, Ventilator Care, Support Surface A or B, or Intensive Tracheostomy Care for more than 50 percent of the care level days paid during a given 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 more than 50 percent of the care level days paid during a given month may also qualify the facility for an enhanced Heavy Special reimbursement rate as described above.

	Revenue Code(s)
A. Special Services	
1. Central Intravenous Care	0269
2. Peripheral Intravenous Care	0260
3. Decubitus Ulcer Care	0550 and 0272
4. Tube Feeding	
a. Medicare	0559
b. Medicaid only	0559 and 0279
5. Ventilator Care	0419
6. Support Surface A	0290
7. Support Surface B	0299
8. Intensive Tracheostomy Care	0413
B. Additional Services	
1. Oxygen/Aerosol Therapy	0412
2. Suctioning/Tracheostomy Care	0410
3. Turning and Positioning	0230
4. Negative Pressure Wound Therapy	0550 and 0270
5. Bariatric Bed A	0946
6. Bariatric Bed B	0291
C. Therapy Services	
1. Physical Therapy	0420
2. Occupational Therapy	0430
3. Speech Therapy	0440

Reimbursement is available when the requirements as delineated in this Handbook are met, and the recipient is present in the facility on the day in question. On those days when the recipient is on a leave of absence, a reduced payment will be made for up to 18 days per calendar year.

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

III. RESIDENT ASSESSMENT SYSTEM

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

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

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

		Self Performance	Support
Dependent:			
MDS 3.0 - Section G - Functional Status			
G0110.B	Transfer	2, 3 or 4	2 or 3
Bed Chair confined:			
MDS 3.0 - Section G - Functional Status			
G0110.A	Bed Mobility	4	2 or 3
G0110.B	Transfer	4	2 or 3
G0110.C	Walk in Room	7 or 8	7 or 8
G0110.D	Walk in Corridor	7 or 8	7 or 8
G0110.E	Locomotion on Unit	0-3[1], 4, 7, or 8	2, 3 or 8
G0110.F	Locomotion Off Unit	0-3[1],4, 7, or 8	2, 3 or 8
G0600	Mobility Devices		C2

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

2 Use of motorized wheelchair must be documented.

OTHER REIMBURSEMENT CATEGORIES

I. HOSPITAL LEAVE (0185)

THIS SERVICE HAS BEEN DISCONTINUED AS A MEDICAID COVERED SERVICE EFFECTIVE 7/1/2012

THIS SERVICE HAS BEEN DISCONTINUED AS A MEDICAID COVERED SERVICE EFFECTIVE 7/1/2012

SPECIAL SERVICES

I. COMMUNICABLE DISEASE CARE (0239)

THIS SERVICE HAS BEEN DISCONTINUED AS A MEDICAID COVERED SERVICE EFFECTIVE 7/1/2012.

INTENSIVE TRACHEOSTOMY CARE (0413) (Effective 7/1/2012)

Item Definition: Any full day that a recipient receives suctioning more frequently than once every four hours, along with other procedures comprising intensive tracheostomy care, to maintain the recipient's airway.

NOTE:

1. The care must be ordered by a physician.
2. Suctioning and monitoring of the recipient's condition must be performed by a respiratory therapist.
3. At a minimum, the resident must require a complete suctioning at least more frequently than every four hours and require suctioning at least seven times in a 24-hour period
4. This includes cleaning of inner and outer cannula, if appropriate, and sterilization of needed equipment.
5. The suctioning equipment must be located in the recipient's room.
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.
7. Payment for intensive tracheostomy care and suctioning/tracheostomy care (revenue code 0410) will not be made for the same day of care.

CLINICAL INDICATORS FOR THE NEED AND DURATION OF SERVICES

1. Recipient has abnormal breath sounds (coarse rhonchi and/or expiratory wheezing) upon auscultation.
2. Recipient demonstrates increased work of breathing as evidenced by use of accessory muscles, orthopnea, supra-clavicular notching on inspiration, decrease in oxygen saturation, and/or cyanosis.
3. Recipient requests suctioning.
4. Resident has visible secretions
5. There is a suspicion that the recipient has aspirated gastric or upper airway secretions.
6. Resident evidences otherwise unexplained increase in shortness of breath, respiratory rate, or heart rate.
7. Resident evidences decreases in vital capacity and/or oxygen saturation thought to be related to mucus plugging.

KEY DOCUMENTATION

1. Treatment and/or Medication Sheets must document the provision of the care and be signed by specified licensed medical personnel for each shift in which the care was provided.
2. Shift note by the respiratory therapist documenting the clinical indications for frequent suctioning, to include a pre-assessment, notation that describes the color, consistency and amount of secretions suctioned, the recipient's tolerance of the procedure, and a post-suctioning assessment. The pre- and post-suctioning assessment should contain objective clinical data such as respiratory rate, oxygen saturation, documentation of breath sounds and any other pertinent clinical data to support the need for frequent suctioning.
3. Physician's Orders that specify the clinical indicators for frequent suctioning, include a respiratory care treatment plan to address the reason for frequent suctioning and other processes related to intensive tracheostomy care, and establishes the goal of decannulation (or provides an explanation of why decannulation is not being pursued.)
4. Monthly Physician Progress Notes for each month during which the resident is receiving frequent suctioning and other processes related to intensive tracheostomy care, which must support continuing need for ITC services. The utilization control agent will review medical documentation for ITC services at the next patient assessment following the beginning of this service.
5. Any ITC services provided after the first three months must be pre-authorized on a quarterly basis by the Program after review by its Physician Program Specialist of documentation of continued medical necessity of the services.

Updates to Handbook Issued 10/1/2010

10/1/2010	Complete Handbook Issued
7/1/2012	Hospital Leave and Communicable Disease Care discontinued; Intensive Tracheostomy Care added; coding for Mobility updated; Title Page updated; Table of Contents updated; pages 2-4, 9, 16-17, 20 updated; pages 31-1 and 31-2 added