STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM

Managed Care Organization Transmittal No. 55
Hospital Transmittal No. 186
Waiver for Adults with Physical Disabilities Transmittal No. 5
Medical Day Care Transmittal No. 50
Nursing Home Transmittal No. 187
Waiver for Older Adults Transmittal No. 10
Physician Transmittal No. 127
Nurse Practitioner Transmittal No. 15
June 14, 2004

TO: Area Agencies on Aging
Hospital Administrators
Living at Home: Maryland Community Choices Case Managers
Medical Day Care Centers
Nursing Facility Administrators
Physicians & Nurse Practitioners
Managed Care Organizations
Federally Qualified Health Centers

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: Medical Eligibility Review Form (DHMH 3871 B, 6/04)

Attached is the new Maryland Medical Assistance Medical Eligibility Review Form for long term care services. This form is the primary instrument for providing information to the Program's Utilization Control Agent regarding an applicant for Medicaid benefits for nursing facility services, Waiver for Older Adults services, *Living at Home* Waiver services, medical day care services or PACE services. The form has been developed to yield functional, cognitive and medical information in an objective and scoreable format, enabling the Agent to render a more accurate determination of the need for services at a nursing facility level of care. Effective July 1, 2004 please use only the form attached to this transmittal when seeking a nursing facility level of care. Please continue to use the DHMH 3871 (Rev. 4/95) when seeking a chronic hospital level of care. Requests for Model Waiver or ventilator care services can be presented on either form. Additional copies of the new DHMH 3871 B (6/04) will be available shortly from the local health department in your area.

DHMH 3871 B has been designed to incorporate instructive guidance such that separate instructions for completion are not necessary. In completing the form, however, it is important to note the following:

1. All areas of the form must be completed. If certain information is unavailable or does not apply to the individual in question, this should be so noted.

2. Although the DHMH 3871 B is the primary instrument for requesting medical eligibility for nursing facility services or their community alternative, any additional information that supports the need for the requested service, such as medical evaluations or AERS evaluations, may also be submitted.

3. For Medicaid nursing facility applicants, the referring source must also submit a signed, dated copy of the PASRR MR/MI Level I Screen Form (DHMH 4345). Documentation of the results of the Level II evaluation and determination must also be submitted when appropriate. Further information on the PASRR Level I and Level II requirements is provided in the Program's Nursing Home Transmittal No. 127.

Process for obtaining medical eligibility for long term care services:

It is important that the application for medical eligibility for long term care services be made before admission to the nursing facility or community program. In post-admission conversions to Medicaid, application should be made as soon as the individual becomes financially eligible. In order to obtain a medical eligibility determination, the original signed DHMH 3871 B, plus any additional documentation as required, must be submitted along with the completed Long Term Care Patient Activity Report (DHMH 257) to:

Delmarva Foundation for Medical Care, Inc.
9240 Centreville Road
Easton, Maryland 21601
Phone (410) 822-0697
Fax (410) 822-1997

For an individual seeking admission to a nursing facility, a preliminary medical eligibility determination may be given by telephone or fax, followed up by submission of the original DHMH 3871 B and 257 forms as described above.

Any questions regarding completion of the DHMH 3871 B or the medical eligibility determination process may be referred to the Long Term Care and Community Support Services Administration, Division of Long Term Care Services, at (410) 767-1444.

Attachment
cc: Nursing Home Liaison Committee
Hopkins ElderPlus
Maryland Department of Aging
Department of Human Resources
Local Health Departments

Maryland Medical Assistance
Medical Eligibility Review Form #3871B

Part A – Service Requested

1. **Requested Eligibility Date:** _____

2. **Admission Date:** _____

3. **Facility MA Provider #:** _____

4. **Check Service Type Below:**

a. ☐ Nursing Facility b. ☐ Medical Adult Day Care c. ☐ Older Adults Waiver

d. ☐ Living at Home Waiver e. ☐ PACE

Part B – Demographics

1. **Client Info:** a. Last Name _____ b. First Name _____ c. MI ____

d. Sex: M F (circle) e. SS#: _____ - _____ - _____

f. MA#: _____ g. DOB: _____

(Permanent Address) h. Address 1 _____

i. Address 2 _____

j. City _____ k. State _____ l. Zip _____

m. Phone (____)_____ - _____

2. **Current location of Individual if in Facility:**

a. Name of Facility _____

b. Address 1 _____

c. Address 2 _____

d. City _____ e. State _____ f. Zip _____

3. **Next of Kin/Representative:**

a. Last Name _____ b. First Name _____ c. MI ____

d. Address 1 _____

e. Address 2 _____

f. City _____ g. State _____ h. Zip _____

i. Phone (____)_____ - _____

4. **Attending Physician:**

a. Last Name _____ b. First Name _____ c. MI ____

d. Address 1 _____

e. Address 2 _____

f. City _____ g. State _____ h. Zip _____

i. Phone (____)_____ - _____

Client's Name _____

Part C – MR/MI Please Complete the Following on All Individuals:

Review Item	Answer Y	Answer N
1. Is there a diagnosis or presenting evidence of mental retardation/related condition, or has the client received MR services within the past two years?	☐	☐
2. Is there any presenting evidence of mental illness? **Please note: Dementia/Alzheimer's is not considered a mental illness.**	☐	☐
a. If yes, check all that apply. _____Schizophrenia _____Personality disorder _____Somatoform disorder _____ Panic or severe anxiety disorder _____ Mood disorder _____Paranoia _____Other psychotic or mental disorder leading to chronic disability		
3. Has the client received inpatient services for mental illness within the past two years?	☐	☐
4. Is the client on any medication for the treatment of a major mental illness or psychiatric diagnosis?	☐	☐
a. If yes, is the mental illness or psychiatric diagnosis controlled with medication?	☐	☐
5. Is the client a danger to self or others?	☐	☐

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

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

Review Item (Please indicate the number of days per week each service is required.)	# of days service is required/wk. (0-7)
1. **Tracheotomy Care:** All or part of the day	
2. **Suctioning:** Not including routine oral-pharyngeal suctioning, at least once a day	
3. **IV Therapy:** Peripheral or central (not including self-administration)	
4. **IM/SC Injections:** At least once a day (not including self-administration)	
5. **Pressure Ulcer Care:** Stage 3 or 4 and one or more skin treatments (including pressure-relieving bed, nutrition or hydration intervention, application of dressing and/or medications)	
6. **Wound Care:** Surgical wounds or open lesions with one or more skin treatments per day (e.g., application of a dressing and/or medications daily)	
7. **Tube Feedings:** 51% or more of total calories or 500 cc or more per day fluid intake via tube	
8. **Ventilator Care:** Individual would be on a ventilator all or part of the day	
9. **Complex respiratory services:** Excluding aerosol therapy, spirometry, postural drainage or routine continuous O2 usage	
10. **Parenteral Feeding or TPN:** Necessary for providing main source of nutrition	
11. **Catheter Care:** Not routine foley	
12. **Ostomy Care:** New	
13. **Monitor Machine:** For example, apnea or bradycardia	
14. **Formal Teaching/Training Program:** Teach client or caregiver how to manage the treatment regime or perform self care or treatment skills for recently diagnosed conditions (**must be ordered by a physician**)	

Client's Name _____

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

Review Item (Please indicate the number of days per week each service is required.)	# of days service is required/wk. (0-7)
15. **Extensive Training for ADLs:** (restoration, not maintenance), including walking, transferring, swallowing, eating, dressing and grooming	
16. **Amputation/Prosthesis Care Training:** For new amputation	
17. **Communication Training:** For new diagnosis affecting ability to communicate	
18. **Bowel and/or Bladder Retraining Program:** Not including routine toileting schedule	

Part E – Functional Assessment

Review Item	Answer Y	Answer N
Cognitive Status (Please answer Yes or No for EACH item.)		
1. **Orientation to Person:** Client is able to state his/her name.	☐	☐
2. **Medication Management:** Able to administer the correct medication in the correct dosage, at the correct frequency without the assistance or supervision of another person.	☐	☐
3. **Telephone Utilization:** Able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.	☐	☐
4. **Money Management:** Can manage banking activity, bill paying, writing checks, handling cash transactions, and making change without the assistance or supervision of another person.	☐	☐
5. **Housekeeping:** Can perform the minimum of washing dishes, making bed, dusting, and laundry, straightening up without the assistance or supervision of another person.	☐	☐
6. **Mini-Mental Results:** Was the entire Folstein Mini-Mental test completed? **(If all questions are not answered, answer NO.)** **If yes, indicate the final score. If no, indicate reason.** (Examination should be administered in a language in which the client is fluent.)	☐	☐
	If Yes, Score: _____	
	If No, check one of the following: ☐ Visual Loss ☐ Hearing Loss ☐ Loss of Motor Ability ☐ Language Barrier ☐ Refused ☐ Less than 8th Grade Education	
Behavior (Please answer Yes or No for EACH item.)	Answer Y	Answer N
7. **Wanders (several times a day):** Moves with no rational purpose or orientation, seemingly oblivious to needs or safety.	☐	☐
8. **Hallucinations or Delusions (at least weekly):** Seeing or hearing nonexistent objects or people, or a persistent false psychotic belief regarding the self, people, or objects outside of self.	☐	☐
9. **Aggressive/abusive behavior (several times a week):** Physical and verbal attacks on others including but not limited to threatening others, hitting, shoving, scratching, punching, pushing, biting, pulling hair or destroying property.	☐	☐
10. **Disruptive/socially inappropriate behavior (several times a week):** Interferes with activities of others or own activities through behaviors including but not limited to making disruptive sounds, self-abusive acts, inappropriate sexual behavior, disrobing in public, smearing/throwing food/feces, hoarding, rummaging through others' belongings, constantly demanding attention, urinating in inappropriate places.	☐	☐
11. **Self-injurious behavior (several times a month):** Repeated behaviors that cause injury to self, biting, scratching, picking behaviors, putting inappropriate object into any body cavity, (including ear, mouth, or nose), head slapping or banging.	☐	☐

Client's Name _____

Communication (Please answer Yes or No for EACH item.)	Answer Y	Answer N
12. Hearing Impaired even with use of hearing aid: Difficulty hearing when not in quiet setting, understands conversations only when face to face (lip-reading), can hear only very loud voice or totally deaf.	☐	☐
13. Vision Impaired even with correction: Difficulty with focus at close range, field of vision is severely limited (tunnel vision or central vision loss), only sees light, motion, colors or shapes, or is totally blind.	☐	☐
14. Self Expression: Unable to express information and make self understood using any means (with the exception of language barrier).	☐	☐
Review Item		
FUNCTIONAL STATUS: Score as Follows **0 = Independent:** No assistance or oversight required **1 = Supervision:** Verbal cueing, oversight, encouragement **2 = Limited assistance:** Requires hands on physical assistance **3 = Extensive assistance:** Requires full performance (physical assistance and verbal cueing) by another for more than half of the activity **4 = Total care:** Full activity done by another	**Score Each Item (0-4)**	
15. Mobility: Purposeful mobility with or without assistive devices.		
16. Transferring: The act of getting in and out of bed, chair, or wheelchair. Also, transferring to and from toileting, tub and/or shower.		
17. Bathing (or showering): Running the water, washing and drying all parts of the body, including hair and face.		
18. Dressing: The act of laying out clothes, putting on and removing clothing, fastening of clothing and footwear, includes prostheses, orthotics, belts, pullovers.		
19. Eating: The process of putting foods and fluids into the digestive system (including tube feedings).		
20. Toileting: Ability to care for body functions involving bowel and bladder activity, adjusting clothes, wiping, flushing of waste, use of bedpan or urinal, and management of any special devices (ostomy or catheter). This does not include transferring (See transferring item 16 above).		
CONTINENCE STATUS: Score as Follows **0 =Independent:** Totally continent, can request assistance in advance of need, accidents only once or twice a week or is able to completely care for ostomy. **1 = Dependent**: Totally incontinent, accidents three or more times a week, unable to request assistance in advance of need, continence maintained on toileting schedule, indwelling, suprapubic or Texas catheter in use or unable to care for own ostomy	**Score Each Item (0 or 1)**	
21. Bladder Continence: Ability to voluntarily control the release of urine from the bladder.		
22. Bowel Continence: Ability to voluntarily control the discharge of stool from the bowel.		

Part F – Certification

1. a. Signature of Person Completing Form: _____ b. Date: _____

c. Printed Name: _____

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

2. a. Signature of Health Care Professional: _____ b. Date: _____

c. Printed Name: _____