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 – S. Anthony McCann, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 202

April 11, 2006

TO: Chronic Hospital Administrators
Nursing Home Administrators
Hospital Discharge Planners

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: Utilization control criteria for ventilator patients

This transmittal establishes guidelines for determining medical eligibility for Medicaid-funded chronic hospital services for ventilator-dependent patients.

Currently, people use ventilators in a variety of settings. More than a quarter of all chronic hospital patients have respiratory problems that require ventilator support. In addition, over the last decade several nursing facilities have established specially licensed respiratory care units that serve ventilator patients. Other individuals use ventilators in the community and live in their own homes.

As medical practice evolves and new technologies emerge, the Department of Health and Mental Hygiene's goal is to facilitate access to medically necessary ventilator care while ensuring that people receive services in the least restrictive, most cost-effective setting appropriate to their needs. The criteria and guidelines in this transmittal are written to be flexible and responsive to the evolving patterns of ventilator care.

General Medical Eligibility Criteria

The Medicaid Program may cover chronic hospital services for ventilator patients if such services are reasonable and necessary for the treatment of the patient's condition and the patient's condition makes it necessary to receive services in a hospital inpatient setting, not on an outpatient basis or in a less intensive setting such as a nursing facility.

Guidelines

The following guidelines are intended to help the Department and its utilization control agent to determine if chronic hospital services are necessary.

Generally, chronic hospital services are necessary for patients with:

- unstable respiratory status requiring daily monitoring of unstable blood gases; or

- medical conditions that – either independently or in combination with respiratory status – fluctuate sufficiently to require frequent physician intervention and monitoring. Special focus may be warranted for severe cardiac, endocrine, and psychiatric comorbidities.

Weaning status, chest tubes, frequent suctioning, wound care, and the length of time that a patient has been on a ventilator will be considered as part of the medical eligibility determination. However, independent of other conditions, none will automatically qualify a patient for chronic hospital eligibility.

Utilization Review Process

The Department's utilization control agent will have the primary responsibility for making medical eligibility determinations. For ventilator patients, all medical eligibility requests will go directly to physician review.

To help the utilization control agent make informed medical eligibility decisions for ventilator patients, a physician or nurse practitioner must sign several completed forms, described below. Copies of these forms are attached to this transmittal.

- DHMH Form 3871b – this form captures selected skilled nursing, therapy, functional, cognitive, and behavioral information

- Additional Information Form – this form captures medical information not necessarily reflected in the 3871b

- Vent Specific Question Form – this form asks several questions specific to respiratory status

- Patient Comorbidity Rating Scale – this scale helps gauge the severity of comorbidities

It is imperative that these forms be complete and accurate. In addition, the utilization control agent will accept any additional information and documentation that is not already captured through these forms.

Administrative Days

For patients already approved for chronic hospital services, the Department's utilization control agent will perform periodic continued stay reviews to determine if chronic hospital services remain necessary and appropriate. Some chronic hospital patients will qualify for chronic hospital services temporarily, then be found eligible only for a lower level of care. Under certain circumstances, the Medicaid Program may pay for administrative days when a patient no longer qualifies for chronic hospital care but continues to receive services in the facility. The regulation governing administrative days is COMAR 10.09.06.10.

The fiscal year 2006 administrative day rate for ventilator patients is $603.28. The current administrative day rate for non-ventilator patients is $187.05.

If you have questions about this transmittal, please call the Division of Long Term Care Services at 410-767-1736.

Attachments

cc: Nursing Home Liaison Committee

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	
Cognitive Status (Please answer Yes or No for EACH item.)	Y	N
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	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: _____

Additional Information Form

Demographics

Last Name:_____First Name:_____MI: _____

SS#:_____MA#:_____DOB:_____

Primary Diagnosis:_____

Secondary/Surgical Diagnoses requiring MD and/or Nursing Intervention, which relate to the need for a level of care:

_____

_____

_____

_____

Other Pertinent Findings (ex: signs/symptoms, complications, lab results, etc.):

_____

_____

_____

_____

Have there been any hospitalizations within the last 3 months? If yes, reason:

_____

_____

Diet (include supplements) _____

Ht: _____ Wt_____ BP_____

Have any of the above vital signs changed recently Yes___ No____If yes, explain in detail.

_____

_____

Medication	Dosage	Frequency	Route	Reason for Giving

Are any of the above medications new, being frequently adjusted or are there other problems associated with them? If yes, please explain: _____

_____

_____

Any other medical information pertinent to the need for a level of care:

_____

_____

_____

_____ _____

Signature of Health Care Professional Date

Vent Specific Question Form

A. What is the PEEP setting? _____

B. What is the current Fi02 level? _____

C. Have there been any significant changes in the level or setting as noted in A or B above? Yes No

If yes, please explain. _____

_____

D. Is there a chest tube or tubes? Yes No

E. Does the patient require suctioning? Yes No
If yes, how often? _____

_____

F. Does the patient require isolation? Yes No
If yes, please explain. _____

_____

G. Is the patient being weaned? Yes No

H. Is weaning to be started in the next 30 days? Yes No
If yes, please explain reason and plan. _____

_____

I. Has weaning been attempted in the past? Yes No
If yes, please provide details including dates and results. _____

_____

J. Is the patient currently receiving pulmonary rehabilitation? Yes No
If yes, please explain, including frequency. _____

_____

K. Has the patient been on a ventilator for less than six months? Yes No
How long has the individual been on a ventilator? _____

L. Is patient's 02 level stable? If not, please explain: _____

_____

M. Number of times blood gases have been required in the last 2 weeks. _____

N. If patient is currently in a chronic hospital, please provide the date of last acute hospitalization and the reason for transfer to the chronic hospital. _____

O. If patient is currently in a nursing home, please provide the date of last acute hospitalization and the reason for transfer to the nursing home. _____

_____

P. If the patient has required transfer to an emergency room in the last 30 days, please provide the number of times and the reasons. _____

_____

_____ _____

Signature of Health Care Professional Date

Patient Comorbidity Rating Scale Signature of Health Care Professional _____ Date _____

	0- NONE	1 - MILD	2 - MODERATE	3 - SEVERE	4-EXT SEVERE	SCORE
1. Cardiac (heart only)						
2. Hypertension (affected systems rated separately)						
4. Respiratory (lungs, bronchi, trachea below the larynx)						
5. EENT (eye, ear, nose, throat, larynx)						
6. Upper GI (esophagus, stomach, duodenum, biliary and pancreatic trees; do not include diabetes)						
7. Lower GI (intestines, hernias)						
8. Hepatic (liver only)						
9. Renal (kidneys only)						
10. Other GU (ureters, bladder, urethra, prostate, genitals)						
11. Musculo-Skeletal-Integumentary (muscles, bone, skin)						
12. Neurological (brain, spinal cord, nerves; do not include dementia)						
13. Endocrine-Metabolic (includes diabetes, diffuse infections, infections, toxicity)						
14. Psychiatric/Behavioral (includes dementia, depression, anxiety, agitation, psychosis)						
TOTAL SCORE						

0 = NONE: No impairment to that organ/system
1 = MILD: Impairment does not interfere with normal activity; treatment may or may not be required; prognosis is excellent (Examples could be skin lesions, hernias, or hemorrhoids)
2 = MODERATE: Impairment interferes with normal activity; treatment is needed; prognosis is good (Examples could be gallstones, diabetes, or fractures)
3 = SEVERE: Impairment is disabling; treatment is urgently needed; prognosis is guarded. (Examples could be resectable carcinoma, pulmonary emphysema, or congestive heart failure)
4 = EXTREMELY SEVERE: Impairment is life threatening; treatment is urgent or of no avail; prognosis is grave. (Examples could be myocardial infarction, cerebrovascular accident, gastrointestinal bleeding, or embolus)