MedStar Family Choice

ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**162**	
Subject:	**Placements – Long Term Care, Skilled, Sub-Acute, Acute, Rehabilitation, and MCO Disenrollments to Long Term Care**	
Section:	**Care Management**	
Initial Effective Date:	**09/01/2000**	
Revision Effective Date(s):	**07/18, 07/19, 07/20, 07/21, 07/22, 02/23, 07/23**	
Historical Revision Date(s):	**10/01, 09/02, 04/03, 10/03, 09/04, 10/05, 12/06, 10/07, 09/08, 11/09, 09/10, 09/11, 10/12, 11/13, 07/14, 10/14, 10/15, 10/16, 01/17, 07/17**	
Review Effective Date(s):		
Historical Review Date(s):		
Responsible Parties:	**Carol Attia, Blaine Willis**	
Responsible Department(s):	**Clinical Operations**	
Regulatory References:	**COMAR: 10.67.06.12, MDH Hospital Transmittal No. 245, MDH Nursing Home Transmittal No. 213, MDH MCO Transmittal No. 165/Nursing Homes Transmittal No. 287**	
Approved:	**Carol Attia, MBA, BSN, RN, VP Clinical Care & Quality**	**Karyn Wills, MD Chief Medical Officer**

Purpose: **To define a process for arranging for inpatient alternatives to acute care.**

Scope: **MedStar Family Choice, Maryland**

Policy: **Care Management staff will collaborate with the MedStar Family Choice (MFC) Post-acute Case Manager(s) to assure appropriate placements to post acute care facilities and process for coordinating disenrollments from Managed Care Organization (MCO) to long term care.**

Procedure:

A. Inpatients:
    1. The MFC Post-Acute Case Manager (CM) reviews cases upon admission for any anticipated placement needs. Hospital CMs are requested to discuss length of stay, and anticipated care needs with the member and family.
    2. The CM uses InterQual, and MDH Nursing Home Transmittal No. 213 along with information from the hospital (including discharge screens) to assure medical necessity and the appropriate level of care. If a member will require care in another facility beyond discharge, the Hospital CM is educated as to in-network facilities, which have the capability of providing the needed care. The name and number of the MFC Post-Acute CM is provided.
    3. Out-of-network facilities may be considered in the following circumstances:
        a. The patient requires care that is not available at an in-network facility.
        b. There are no beds available at any in-network facilities.
    4. The Hospital CM and/or the facility liaison will call the MFC Post-Acute CM to arrange admission to the facility. Demographic and clinical information are provided. The minimum necessary information will be provided to the MFC Post-Acute CM.
    5. If the member meets Post-Acute InterQual Criteria, the MFC Post-Acute CM will negotiate a level of care, assign an initial length of stay, and create the authorization in the clinical software system. Authorizations for specialized services such as transportation, intravenous antibiotics, and specialty beds will also be provided.
    6. When the Subacute/ Skilled Nursing Facility (SAC/SNF) criteria in InterQual is exhausted after the first 28 - 42 days of a member's stay and the member remains at the SAC/SNF facility; the MFC nurse reviewer can approve a member's continued stay when the following conditions are met up to day 90 of the stay.
        a. Member is still receiving one or more disciplines of PT, OT or ST and progressing toward goals.
        b. Member is receiving IV antibiotic therapy and their condition or social situation does not allow them to receive this service safely in a home setting.
        c. Member is receiving wound care and the member cannot be taught, is not physically capable to complete, does not have adequate support at home, or the wound care cannot be provided through home care due to the frequency or complexity of care.
        d. Member needs additional teaching on their disease state and/or medication management due to cognitive issues.
        e. Medical management that is needed cannot be safely completed in a home setting due to the frequency or complexity of care.
        f. Member can no longer care for self and there are no family members or willing family members to care for member and the plan is to reside in the SAC/SNF as a long-term care resident.
        g. Member is determined to be a member above custodial care not requiring skilled nursing services or rehabilitation services may be determined medically eligible for a SAC/SNF if they require, on a regular basis, health-related services above the level of room and board. These services are described as follows:

i. Care of an individual who requires hands-on assistance to adequately and safely perform two or more activities of daily living (ADLs)[1] as a result of a current medical condition or disability; or

ii. Supervision of an individual's performance of two or more ADLs for an individual with cognitive deficits, as indicated by a score of 15 or less on the Folstein Mini-Mental Status Evaluation, and who is in need of assistance with at least three instrumental activities of daily living (IADLs)[2]; or

iii. Supervision of an individual's performance of two or more ADLs combined with the need for supervision/redirection for an individual exhibiting at least two of the following behavior problems: wandering several times a day, hallucinations/delusions at least weekly, aggressive/abusive behavior several times a week, disruptive/socially inappropriate behavior several times a week, and/or self-injurious behavior several times a month.

7. If the patient does not meet Post-Acute InterQual Criteria, the MFC Post-Acute CM will forward a referral to the Medical Director within the same day of receiving clinical information. The Medical Director will render a decision. Written notification for any adverse decisions will occur, according to Code of Maryland Regulations (COMAR) guidelines and UM Process Policy 110.
8. If MFC denies authorization for admission into a subacute/skilled nursing facility aka long-term care facility (LTCF) for not meeting medical necessity criteria; MFC must pay the administrative day rate through the date of MFC's proposed discharge date. The enrollee then becomes liable for the cost of any additional days in the LTCF beyond the proposed discharge date.
9. During an enrollee's stay in a LTCF and MFC determines the enrollee does not meet InterQual Criteria for skilled nursing level of care, and the enrollee (or LTCF with enrollee's consent) fails to appeal the MCO's decision, the MCO must then determine if the enrollee meets MDH's custodial level of care criteria.
    - If the enrollee meets MDH's custodial level of care criteria, MFC will approve and reimburse the LTCF at the administrative day rate so long as the enrollee continues to qualify under the criteria.
    - If the enrollee fails to meet MDH's custodial level of care criteria, MFC will approve and pay the administrative day rate until the enrollee is safely discharged to the appropriate level of care as per the treatment plan.
    - The SAC/SNF cannot bill the enrollee the difference between the administrative day rate and the skilled nursing rate.
10. The MFC Post-Acute CM will collaborate with the Hospital CM to identify alternatives for difficult to place patients.
11. Maryland MCO members who have an anticipated length of stay greater than 90 days will require a Maryland Department of Health (MDH) form 3871 be submitted by day

[1] For purposes of this document, ADLs consist of bathing, dressing, mobility, toileting/continence, and eating.

[2] For purposes of this document, IADLs consist of telephone use. money management, housekeeping, and medication management

seventy-five (75) to MDH's Department's Utilization Control Agent (UCA). MFC adheres to the 90-day medical necessity criteria established by the 3871. The MFC Post-Acute CM will monitor for notice of disenrollment from the MCO and follow up with MDH if this is not received in a timely manner.

12. Should the UCA decide after the 91st day, MFC remains responsible for payment until the determination is made.

B. Community Patients:
   1. The Post-Acute CM will discuss alternative options of care with the patient, family and Primary Care Physician (PCP). The CM will verify identification and authority to discuss this information prior to any information being released.
   2. The CM will coordinate completion of necessary paperwork for placement including the Primary Care Provider writing orders for medications, therapy, wound care, etc., MMRI screen, and assist in retrieving documentation of a recent chest x-ray, PPD, PT/OT/SLP evals or discharge summary.
   3. The CM will discuss the case with the MFC Post-Acute CM(s) to assure appropriate alternatives are presented to the patient.
   4. The CM will contact the facility liaison(s) or admissions coordinator(s) to assess the patient for admission.
   5. The facility liaisons will contact the MFC Post-acute Case Manager to coordinate the level of care, initial length of stay, and to receive necessary authorizations.

References

1. Reference A: Nursing Home Transmittal No. 213
2. Reference B: Hospital Transmittal No. 245
3. Reference C: MCO Transmittal No. 165/Nursing Home Transmittal No. 287

Reference A: Nursing Home Transmittal No. 213

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
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

PT 32-08

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 213
Hospital Transmittal No. 200
Medical Day Care Transmittal No. 61

July 1, 2008

TO: Nursing Home Administrators
Hospital Administrators
Medical Day Care 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 for Nursing Facility Level of Care

The Maryland Medical Assistance Program is issuing this transmittal to describe the medical eligibility criteria used to determine the need for nursing facility services (NFS). This transmittal replaces Nursing Home Transmittal No. 135.

In order to receive Medicaid benefits for services in a nursing facility or through the Living at Home Waiver, Older Adults Waiver, Medical Day Care Waiver, or other service requiring the need for a nursing facility level of care,[1] an individual must meet certain medical eligibility criteria. The bases for these criteria are set forth in both federal and State regulations. In interpreting these regulatory criteria, the Program will use the following guidelines. Nursing facility services are services provided to individuals who, because of their mental or physical condition, require 1) skilled nursing care and related services, 2) rehabilitation services, or 3) on a regular basis, health-related services above the level of room and board. These services are not intended to supplant services that are provided by a hospital, IMD, or ICF/MR.

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[1] Including the Model Waiver for Disabled Children and the Waiver for Adults with Traumatic Brain Injury, for which individuals may also qualify if they are medically eligible for special hospital services, and the Programs of All-Inclusive Care for the Elderly (PACE).

Skilled Nursing Services and Rehabilitation Services

An individual meets the medical eligibility requirements for NFS if a skilled nursing service or rehabilitation service is required on a daily basis.[2] Skilled nursing services and rehabilitation services are those ordered by a physician, and requiring the skills of technical or professional personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, and speech pathologists or audiologists on a daily basis. These services include, but are not limited to, the following:

1. Suctioning, not including routine oral-pharyngeal suctioning;
2. IV Therapy;
3. Pressure ulcer care for Stage 3 or 4 ulcers or wound care for surgical wounds/open lesions with one or more skin treatments (including pressure-relieving bed, nutrition or hydration intervention, application of dressing and/or medications);
4. Enteral or parenteral feeding with 26 percent or more of total calories or 500cc or more per day fluid intake via tube;
5. Ventilator care or other complex respiratory services, excluding aerosol therapy, spirometry, postural drainage or routine continuous oxygen usage;
6. Extensive physical therapy or training for restoration – not maintenance – of physical functioning, including walking, transferring, swallowing, eating, dressing and grooming; and,
7. Other services described in 42 CFR §§409.31 through 409.35.

Health-Related Services Above the Level of Room and Board

Individuals not requiring skilled nursing services or rehabilitation services may be determined medically eligible for NFS if they require, on a regular basis, health-related services above the level of room and board. These services are described as follows:

1. Care of an individual who requires hands-on assistance to adequately and safely perform two or more activities of daily living (ADLs)[3] as a result of a current medical condition or disability; or

2. Supervision of an individual's performance of two or more ADLs for an individual with cognitive deficits, as indicated by a score of 15 or less on the Folstein Mini-Mental Status Evaluation, and who is in need of assistance with at least three instrumental activities of daily living (IADLs)[4]; or

3. Supervision of an individual's performance of two or more ADLs combined with the need for supervision/redirection for an individual exhibiting at least two of the

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[2] For purposes of determining the frequency of skilled nursing or rehabilitation services, "daily" is defined as 5 to 7 days per week.

[3] For purposes of this transmittal, ADLs consist of bathing, dressing, mobility, toileting/continence, and eating.

[4] For purposes of this transmittal, IADLs consist of telephone use, money management, housekeeping, and medication management.

following behavior problems: wandering several times a day, hallucinations/delusions at least weekly, aggressive/abusive behavior several times a week, disruptive/socially inappropriate behavior several times a week, and/or self-injurious behavior several times a month.

Individuals who do not demonstrate the clinical need for health-related services described above may submit additional information for clinical review to demonstrate eligibility under the applicable federal and State regulations.

Questions regarding issues discussed in this transmittal should be directed to the Staff Specialist for the Nursing Home Program at 410-767-1736.

cc: Adult Evaluation and Review Services
Area Agencies on Aging
Hopkins ElderPlus
KePRO
League for Excellence in Adult Daycare
Maryland Association of Adult Day Services
Maryland Department of Aging
Mental Hygiene Administration
Nursing Home Liaison Committee
The Coordinating Center

Reference B: Hospital Transmittal No. 245

PT 15-17

STATE OF MARYLAND

DHMH

Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor – Boyd K. Rutherford, Lt. Governor – Van T. Mitchell, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Hospital Transmittal No. 245
MCO Transmittal No. 113
Nursing Home Transmittal No. 261
December 8, 2016

TO: MCOs
Nursing Homes
Specialty Pediatric Hospitals
Chronic Hospitals

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

RE: Roles and Responsibilities of Nursing Facilities, Specialty Pediatric Hospitals and Chronic Hospitals when Admitting HealthChoice MCO Members

NOTE: Please ensure that the appropriate staff members in your organization are informed of the content of this transmittal.

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The purpose of this transmittal is to inform nursing facilities, specialty pediatric hospitals, and chronic hospitals of a change in HealthChoice MCO coverage and to remind providers of their roles and responsibilities when admitting Medicaid participants. This transmittal replaces Hospital Transmittal No. 180, MCO Transmittal No. 36, and Nursing Home Transmittal No. 179 dated January 10, 2003 (https://mmcp.dhmh.maryland.gov/docs/PT12-03.pdf).

The Medicaid Program covers nursing facility services for individuals who need skilled nursing, rehabilitation or health-related services above the level of room and board. Please see Nursing Home Transmittal Nos. 213 and 237 for more information on level of care standards at: https://mmcp.dhmh.maryland.gov/docs/PT%2032-08.pdf and https://mmcp.dhmh.maryland.gov/MCOupdates/pdf/PT%2010-12%20Various%20Programs.pdf.

Beginning on January 1, 2017, MCOs will be responsible for payment for their members for up to 90 days in a nursing facility, specialty pediatric hospital, or chronic hospital (COMAR 10.09.67.12). For an admission occurring prior to January 1, 2017, MCOs were only responsible for the first 30 days.

Facility staff must verify Medicaid eligibility using the State's online Eligibility Verification System (EVS) or phone 1-866-710-1447 to determine Medicaid status and to identify if the individual is enrolled in an MCO. For individuals who are not enrolled in an MCO, the facility must contact the Department's Utilization Control Agent (UCA). If the individual is enrolled in an MCO, even if Medicaid coverage is secondary insurance, the facility must contact the MCO. The MCO is

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

responsible, in collaboration with the facility staff, to determine the purpose of the admission and the expected duration. The facility must inform the MCO of the requested admission and obtain the MCO's approval prior to the admission. When it is not possible to contact the MCO prior to the admission, the MCO must be informed of the admission by the next business day. MCO contact information is provided at the end of this transmittal.

Responsibility for Payment

- If an individual is financially and medically eligible for Medicaid, and is not HealthChoice eligible or has not yet been assigned to an MCO, all services will be covered by Medicaid fee-for-service for up to 30 days and the individual will not be enrolled in an MCO. On day 31, the individual can apply for Medicaid services in a nursing facility, specialty pediatric hospital, or chronic hospital if applicable.

- If an individual is enrolled in an MCO at the time of admission to a nursing facility, specialty pediatric hospital, or chronic hospital, the MCO is responsible for preauthorizing the stay and the MCO is responsible for all payment of services during the stay, up to and including the 90th day, as long as the individual continues to be enrolled in the MCO and meets the level of care standard.

- If a HealthChoice eligible individual loses Medicaid eligibility while in a nursing facility, specialty pediatric hospital, or chronic hospital and subsequently regains Medicaid eligibility, the individual will not be re-enrolled in the MCO.

- If an individual enrolled in an MCO becomes ineligible for HealthChoice (qualifies for Medicare or becomes age 65) while in a nursing facility, specialty pediatric hospital or chronic hospital, the individual will be disenrolled from the MCO and the remaining stay will be covered under Medicaid fee-for-service if all requirements are met.

Please note that an individual may be in the process of being assigned to an MCO at the time of admission. If the Department is not informed that the individual is in a facility, the MCO enrollment transaction will occur. The facility will need to take action to invalidate the MCO enrollment by immediately faxing DHMH Form 257 to the HealthChoice Enrollment Unit at 410-333-7141. Do not send requests for disenrollment for anyone who was in an MCO on the day of admission to the facility.

Stays Expected to Exceed 90 Days

It is the facility's responsibility to contact the Department's UCA to affirm that the individual continues to need the institutional level of care beyond the 90th day. The MCO must work collaboratively with the facility to ensure that this process occurs on a timely basis. In order to assure the individual is disenrolled from the MCO on the 91st day, the facility should request the appropriate level of care from the Department's UCA on the 75th day of admission. An MCO's financial responsibility ends on the 91st day, or the day the Department's UCA receives all necessary information to determine the need for the institutional level of care, whichever is later.

Questions related to medical eligibility nursing facility or specialty hospital services may be directed to the Division of Long Term Care Services at 410-767-1736.

MCO Contacts

MCO	TELEPHONE	FAX
Amerigroup	410-981-4057 410-981-4000 x-44267	877-855-7559
Jai Medical Systems	410-433-5600 – Opt 10	410-433-8500
Kaiser Permanente	703-439-8225	855-414-1707
Maryland Physicians Care	410-401-9459	860-902-8745
MedStar Family Choice	410-933-2241	410-933-2274
Priority Partners	410-762-5303 410-762-1576	410-762-5303 410-762-1576
UnitedHealthcare	866-604-3267 301-865-0419	855-695-2398
University of Maryland Health Partners (formerly Riverside Health)	410-779-9359	410-779-9336

Reference C: MCO Transmittal No. 165/Nursing Home Transmittal No. 287

PT 36-23

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
MCO Transmittal No. 165
Nursing Homes No. 287
Chronic Hospital No. 3
Special Pediatric Hospital No. 2
January 19, 2023

TO: Managed Care Organizations
Nursing Homes
Chronic Hospitals
Special Pediatric Hospitals

FROM: Sandra Kick
Director, Medical Benefits Management

Marlana R. Hutchinson
Director, Office of Long Term Services and Supports

RE: Clarification of HealthChoice Coverage for Long Term Care Facilities

NOTE: **Please ensure that the appropriate staff members in your organization are informed of the content of this transmittal.**

This transmittal clarifies previous guidance issued about long term care coverage when an enrollee is enrolled in a HealthChoice managed care organization (MCO). This transmittal should be reviewed in conjunction with Nursing Home Transmittal No. 213/Hospital Transmittal No. 200/Medical Day Care Transmittal No. 61, dated July 1, 2008, and further clarifies responsibility for payment guidance in Hospital Transmittal No. 245/MCO Transmittal No. 113/Nursing Home Transmittal No. 261, dated December 8, 2016

Since January 2017, MCOs have been responsible for their enrollees' stay up to 90 days in a nursing facility, specialty pediatric hospital, or chronic hospital. To determine if an enrollee is eligible for long term care services, MCOs may use evidence-based medical necessity criteria for skilled nursing care, in addition to the Department's long term care criteria, for determining if the stay is appropriate.

Authorization

The long term care facility (LTCF) must seek prior authorization from the MCO for admission to the LTCF to receive payment for the stay. Authorization requests should follow the requirements outlined in COMAR 10.67.09.04. MCOs are responsible for verifying throughout the stay that the enrollee remains eligible for a skilled nursing level of care, as determined by the MCO's criteria.

If the authorization request is denied because the enrollee does not meet medical necessity criteria, LTCFs may assist enrollees with filing an appeal to the MCO using the process outlined in COMAR 10.67.09.05. LTCFs must have written consent from the enrollee or the enrollee's authorized representative to appeal a denied authorization or service day. Only the enrollee or the enrollee's authorized representative may request continuation of benefits during the appeal.

MCOs denying authorization for admission into a LTCF must work with the enrollee, the enrollee's authorized representative (if applicable), and the LTCF to implement an appropriate diversion or discharge plan with a proposed discharge date. The plan must take into account the enrollee's needs and available covered services to assist the enrollee's transition into the community. MCOs must reimburse at an administrative day rate until the enrollee is safely discharged from the LTCF. If the member and/or the LTCF refuses to cooperate with the MCO's discharge plan, and an appeal has not been filed, the MCO is responsible for reimbursing the administrative day rate through the date of the MCO's proposed discharge date. The enrollee then becomes liable for the cost of any additional days in the LTCF beyond the proposed discharge date.

Skilled Nursing Days and Administrative Days

Should the enrollee qualify for skilled nursing care in accordance with the MCO's evidence-based criteria, each MCO is responsible for reimbursing the LTCF at the skilled nursing rate. During the enrollee's stay, if the MCO determines the enrollee does not meet an evidence-based skilled nursing level of care, and the enrollee (or LTCF with the enrollee's consent) fails to appeal the MCO's decision, the MCO must then determine if the enrollee meets the Department's level of care criteria.

- If the enrollee meets the Department's level of care criteria, the MCO is responsible for reimbursing the LTCF at an administrative day rate so long as the enrollee continues to qualify under that criteria. The MCO administrative day rate for the Department's level of care criteria must include any clinical costs, along with the costs of room and board.

- If the enrollee fails to meet the Department's level of care criteria, the MCO will pay the administrative day rate until the enrollee is safely discharged to the appropriate level of care as per the treatment plan.

The MCO and/or the LTCF must document if an enrollee or the LTCF is refusing to cooperate with the discharge plan, or if they are unable to locate an appropriate placement. If the enrollee and LTCF refuse to cooperate with the discharge plan, the MCO is responsible for reimbursing

the administrative day rate through the date of the proposed discharge. The enrollee then becomes liable for the cost of any additional days in the LTCF beyond the proposed discharge date.

Facility Stays Beyond 90 Days

Consistent with COMAR 10.67.04.12, if an enrollee's admission into the LTCF is authorized by the MCO, and the enrollee is expected to qualify for an evidence-based skilled nursing level of care or the Department's custodial criteria for the 90-day period, the LTCF is required to request a level of care determination from the Department's Utilization Control Agent (UCA) on the 75th day so that, if the criteria is met, the enrollee can disenroll from the MCO to fee-for-service coverage on the 91st day. Should the UCA decide after the 91st day, the MCO remains responsible for payment until the determination is made.

Regardless of the MCO or UCA determination, facilities cannot bill enrollees the balance of the cost of the LTCF stay if the days are determined to be covered. For example, if an MCO determines an enrollee qualifies for the administrative day rate under the Department's long term care criteria, a LTCF may not bill the enrollee the difference between the administrative day rate and the skilled nursing rate.

If you have any questions about this transmittal, please contact the following:

- Managed Care Organizations: Bernadette Benta, Division Chief, Complaints Resolution, bernadette.benta@maryland.gov
- Chronic Hospitals & Nursing Facilities: Jane Sacco, Division Chief, Long Term Care Services jane.sacco@maryland.gov

Summary of Changes:	**07/23:** • Procedure A # 6 updated reference for InterQual days from 28 to 28-42 days to be align with 2023 updates for additional weeks of coverage. **02/23:** • Responsible parties removed Theresa Bittle and added Carol Attia. • Regulatory References updated with MDH MCO Transmittal No. 165/MDH Nursing Homes Transmittal No. 287. • Approve section removed Theresa Bittle and Patryce Toye and added Carol Attia and Karyn Wills. • Procedure A #7 added language to include UM Process Policy 110. • Procedure A added a new # 8 & 9 with the language regarding payment of Administrative Days per MDH MCO Transmittal No. 165/Nursing Homes No. 287. • Procedure A #11 added clarifying language about submitting the level of care to the Utilization Control Agent. • Procedure A #12 is new language indicating MFC is responsible for payment if the UCA makes a decision on a level of care after day 91.

	• Eliminated Section C regarding the denial letters since Procedure A #7 indicates with follow COMAR and UM Process Policy 110 for denials. • Added Reference C MDH MCO Transmittal No. 165/Nursing Homes No. 287. **07/22:** • Section A, # 3 b added There are no beds available at any in-network facilities. • Added screenshots of references to policy. **07/21:** • Changed Case Management to Clinical Operations in Responsible Departments. • Added "Maryland" to scope. **07/20:** • Updated Regulatory References to reflect COMAR recodification. • Section A # 6 new procedures added to allow the nurse to approve continued SAC/SNF stays beyond what is allowed by InterQual up to day 90. • Section B # 2 clarified what documentation is needed to place a member from the community in a skilled facility. **07/19:** • Removal of "Maryland" from scope. • Section C #1 removed last sentence about signing the Medical Directors name to the letter. **07/18:** • Removed Sharon Henry from Responsible Parties. • Added COMAR: 10.09.67.12, MDH Hospital Transmittal No. 245, MDH Nursing Home Transmittal No. 213 to Regulatory References. • Clarify that MFC also uses MDH Nursing Home Transmittal No. 213 to evaluate for placement. • Removed all of the DC references in the Regulatory References. • #6 removed the text for District of Columbia contract. • #9 & #10 deleted as these were all reference to process for disenrollment for the DC Health Plan members. • Modified Effective Date to Initial Effective Dates; added Historical Revision Dates and Revision Effective Dates; and added Historical Review Dates and Review Effective Dates. **07/17:** • Added Regulatory Reference: C.6.11.8.1 request for disenrollment.

	• Changed Approved from Carol Attia to Theresa Bittle and updated Dr. Toye's title from Senior Medical Director to Chief Medical Officer. • Changed reference from Physician Advisor to Medical Director. • DHMH to Maryland Department of Health (MDH). • #9 clarified language for DC Health Family Members on which facilities the members can be disenrolled from who have who have stayed greater than 30 days. • Removed language about the denial letter to the member being sent via certified mail. **01/17:** • Changed 30 days to 90 days in #8 in the Inpatient section. • Changed having a completed 3871 by day twenty one (21) to day seventy five (75). **10/16:** • Updated the regulatory references. • CCMS to Clinical Software System. **10/15:** • Policy updated to include MD and DC plans. • Title updated to include placement as well as disenrollment. • Added process to notify DHCF of potential disenrollment to LTC. • Added process for notification of denials for inpatient days in a long term care facility.