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

MARYLAND MEDICAL ASSISTANCE PROGRAM

Nursing Home Transmittal No. 218
April 1, 2009

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: Reimbursement for Power Wheelchairs and Power Wheelchair Repairs

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Under COMAR 10.09.10.10N, nursing home providers may be reimbursed for the cost of power wheelchairs and power wheelchair repairs. The procedure is as follows:

- Providers request preauthorization by the Long Term Care and Community Support Services Administration for a power wheelchair or wheelchair repair, in a format designated by the Administration. Please see the preauthorization request format attached to this transmittal.[1] Completed requests should be sent to:

  The Division of Long Term Care Services
  201 West Preston Street, Room 120-G
  Baltimore, Maryland 21201

- The Administration determines:
  - The medical necessity of the wheelchair or wheelchair repair.
  - Whether the nursing home is conducive to wheelchair traffic.
  - The maximum allowable cost of the wheelchair or wheelchair repair.

- The Administration sends a preauthorization letter to the provider approving or denying the wheelchair or wheelchair repair.

Upon approval of the wheelchair or wheelchair repair, the nursing home:

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[1] In addition to the form, information regarding the cost of the equipment or repair may be required.

- Purchases or rents the wheelchair, or has the wheelchair repaired.
- May request an interim rate revision in the capital cost center (in accordance with COMAR 10.09.10.07A) by submitting documentation of increased costs.
- Reports the cost of the wheelchair or wheelchair repair on the bottom of Schedule H of the Nursing Home Uniform Cost Report.
- Must provide the preauthorization letter and invoice for each wheelchair purchased or repaired during the period as part of the cost report verification.
- Will have the lower of the preauthorized maximum allowable cost, defined as the maximum reimbursement pursuant to COMAR 10.09.12, or the actual cost of each wheelchair or wheelchair repair included in the total allowable reimbursement amount during cost report settlement.

Retroactive Authorization

Regulatory provisions allowing reimbursement for power wheelchairs were adopted effective October 1, 2007. In order to permit providers to receive payment for power wheelchairs and power wheelchair repairs back to October 1, 2007, the Program will accept retroactive requests for authorization as long as the request is **received by the Program no later than April 30, 2009**.

Please submit any questions regarding this transmittal to the Nursing Home Program at 410 767-1736.

SJT/seh
Attachments

cc: Nursing Home Liaison Committee

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL ASSISTANCE PROGRAM
PREAUTHORIZATION REQUEST
POWER WHEELCHAIRS FOR NURSING HOME RESIDENTS INCLUDING REPAIRS

Section I – Recipient Information

MA Number _____

Last Name_____ First Name_____ DOB_____ Sex____

Is discharge anticipated? □ Yes □ No If yes, approximate discharge date_____

Section II – Facility Information

Facility Name_____Provider Number_____

Address_____

Request Date_____ Contact_____Telephone_____

Section III – Requested Equipment/Repairs

# Units	HCPCS	Description	Program Use Only	
			# App	Denial Reason/Comment

For repairs only: was the equipment for which repair is requested purchased before the recipient entered the nursing home? □ Yes □ No

Section IV –Medical/Functional Information

Attending Physician Name_____

Diagnoses related to need for power wheelchair

Dx Code	Description	Dx Code	Description

Recipient's ability to walk with or without the use of a cane or brace (check one in each column)

	In Room	On Unit
Independent (occasional or no assistance needed)		
Supervision (oversight, encouragement, cuing)		
Limited assistance (recipient highly involved, primarily needs non-weight-bearing physical help)		
Extensive assistance (some involvement by recipient, usually needs weight-bearing support, occasional full staff performance)		
Total dependence (full staff performance)		

ADL support needed for walking with or without the use a cane or brace (check one in each column)

	In Room	On Unit
No setup or physical help from staff		
Setup help only		
One person physical assist		
Two + person physical assist		

Furthest distance recipient able to walk without sitting down (check one):

□ Less than 10 ft □ 10 – 25 ft □ 25 – 50 ft □ 51 – 149 ft □ 150+ ft

Is the recipient able to self-propel a manual wheelchair? □ Yes □ No If no, please detail the medical and/or functional problems that prevent the recipient from being able to independently propel a manual wheelchair_____

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_____

Is the recipient able to independently operate the controls of a power wheelchair in a safe manner? □ Yes □ No If no, describe the medical and/or functional problems that prevent the recipient from being able to independently operate a power wheelchair_____

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Additional information to support medical necessity for equipment_____

_____

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IMPORTANT! Please attach a copy of the physician's order. The request will not be considered without a valid physician's order that specifies each equipment item requested.

I certify that the above information is true to the best of my ability. I also certify that the facility in which this equipment is to be used can safely accommodate the use of the wheelchair.

_____ _____ _____ _____

Signature Printed Name Title Date