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
Hospital Transmittal No. 227
Managed Care Organizations Transmittal No. 97
ValueOptions Transmittals No. 1
April 15, 2014

TO: Maryland Hospitals
Managed Care Organizations
ValueOptions

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

RE: Update in Procedure for Submitting Claims Reviews to the Committee

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

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The purpose of this memorandum is to notify Maryland hospitals of a change in procedure for submitting claims to the State's Medical Claims Review Committee (MCRC). The MCRC reviews claims that have been denied by both a participant's Managed Care Organization (MCO) and Value Options (VO), as discussed during the February 21, 2013 Maryland Hospital Association meeting. MCOs have reported that many of the cases forwarded by the MCRC to them for payment were cases in which the MCO requested more documentation and paid the hospital once the requested materials were received, prior to receiving our review decision.

Effective immediately, hospitals and their representatives must fill out the attached form with the claim in question to the Committee. The purpose of this form is to standardize the information being submitted with claims review cases and to ensure that the MCRC is receiving all the necessary facts before its review.

The following criteria must be met before submitting claims to the MCRC for review:

1) All claims must go through the first level of appeals for both Value Options and the patient's MCO;
2) Neither MCO nor VO made payment on any portion of the claim; and
3) The dates of service are within the past year as of January 2014.

Any claims paid in full, except for the psychiatric evaluation, must be sent to the Administrative Services Organization for payment of that particular item.

Hospitals or their representatives must complete the form and attach the required documents before the MCRC will take action on the case. The Department will return incomplete forms and will not initiate review until the hospital or their representatives comply with the procedure previously described.

Please submit any questions about this memo to: Mary.Mussman@maryland.gov

FOR OFFICE USE ONLY:	
Patient Name:	
MCO:	DOS:
Hospital:	Decision:

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MCO/VO Disputed Claims Review Form

Hospitals or their representatives must complete the form and attach the required documents before the Committee will take any action on the case. The Committee will return incomplete forms and will not initiate review until the hospital or their representatives comply.

Hospitals and their representatives must follow the criteria below before submitting their claim:
1) All claims must have gone through the first level of appeal for both Value Options and the patient's MCO; 2) Neither MCO or VO has paid for any portion of the claim; and 3) The dates of service have to be within the past year as of January 2014.

Any claims where everything has been paid except for the psych evaluation need to be sent to the Mental Hygiene Administration Administrative Service Organization (ASO), currently Value Options.

This claims form and the requested attachments should be sent to the following location:
Maryland Department of Health and Mental Hygiene

ATTN: Maryland Claims Review Committee
201 W Preston St
Room 523
Baltimore, MD 21201

(Please note: A completed form has PHI and therefore should be faxed, mailed or sent via secure email)

Hospital Information

Referring Contact:	_____	Email:	_____
Hospital Name:	_____	Phone:	_____
Mailing Address:	_____		

Patient Claim Information

Patient Name: _____ Patient DOB: _____

Patient MA#: _____ Patient MCO: _____

Patient SS#: (if no MA#) _____ Date(s) of Service: _____

Level of Service: (ex: ER, inpatient, etc) _____ Primary Discharge Diagnosis: *(Attach UB04)* _____

Value Options

Date bill submitted to VO: _____ Remittance advice date: _____

Was any portion of the claim paid? Yes ____ No____ Claim total: _____

If yes, how much was paid: _____ Date of payment: _____

If no, what was denial reason?: _____

_____

Report date of appeal/decision: *(Attach all documentation)* _____

Managed Care Organization

Date bill submitted to MCO: _____ Remittance advice date: _____

Was any portion of the claim paid? Yes ____ No____ Claim total: _____

If yes, how much was paid: _____ Date of payment: _____

If no, what was denial reason?: _____

_____

Report date of appeal/decision: *(Attach all documentation)* _____

FOR OFFICE USE ONLY:	
Patient Name:	
MCO:	DOS:
Hospital:	Decision:

THIS SECTION IS FOR DHMH USE ONLY

Brief Synopsis of Case:

Discharge Diagnoses on UB04:

Review Decision: