State of Maryland

MEDICAL CARE POLICY ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201

Parris N. Glendening
Governor

Martin P. Wasserman, M.D., J.D.
Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Hospital Transmittal No. 166
Managed Care Organization No. 1

July 21, 1997

TO: Hospital Administrators
Managed Care Organization Administrators

FROM: Joseph M. Millstone, Director
Medical Care Policy Administration

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

RE: Stop Loss Case Management (SLM) & Rare-Expensive Case Management (REM)

Within the Maryland Medical Assistance HealthChoice Program there are two programs designed for the management of the health care services for particular populations. The Stop Loss Case Management (SLM) Program enrolls recipients who have incurred a certain amount of acute inpatient hospital services. The Rare and Expensive Case Management Program enrolls recipients diagnosed with specific conditions (see attached).

Stop Loss Case Management (SLM)

A managed care organization (MCO) must notify the Stop Loss Program Enrollment Unit that it has or it expects that it will incur expenditures for acute inpatient hospital services supplied to a specific recipient exceeding $61,000 within a contract year (July-June). It is the MCO's responsibility to track its expenditures for acute inpatient hospital services. The MCO must keep the Enrollment Unit advised of its total inpatient expenditures, using the DHMH form 4589-Certification and Enrollment. The MCO should notify the Enrollment Unit not later than 10 days after the MCO learns that costs for a specific recipient have exceeded $35,000. After the $61,000 threshold is reached, the Program and the MCO will share financial responsibility for future acute

(continued on reverse side)

inpatient hospital services. These inpatient hospital services will be paid in accordance with the Medicaid Program's rate of reimbursement as applied to allowed hospital charges, with the Program and MCO splitting the payment, 90%, 10%, respectively. This shared financial responsibility only pertains to acute inpatient hospital services. Any other services, including hospital-based physician services, remain the financial responsibility of the recipient's MCO.

The Stop Loss Program will operate in the following way. At admission, if the hospital receives the Eligibility Verification System (EVS) message that the recipient is enrolled in an MCO, the hospital must contact the appropriate MCO for instructions. It is possible, however, that during a hospital stay a recipient may reach the $61,000 threshold for enrollment into the Stop Loss Program. Although a bill for a particular hospital stay may exceed $61,000, the hospital is to submit the complete bill for that particular hospital stay to the appropriate MCO. The MCO will reimburse the hospital up to the point that the MCO has incurred a total of $61,000 in expenditures for acute inpatient hospital services for that recipient. Once a recipient has met the $61,000 in MCO expenditures, the MCO must notify the Enrollment Unit, and the recipient will be enrolled into the Stop Loss Program. The following message given by the Medicaid Program's EVS will identify a recipient that is in the Stop Loss Program:

"HealthChoice, Stop Loss, call 1-800-565-8190."

If the MCO does not completely pay the submitted claim, and the hospital has verified through EVS that the recipient is enrolled in the Stop Loss Program, the hospital then must resubmit the claim to the Medicaid Program showing the collected amount from the MCO. Also, the hospital must submit an approved DHMH 3808 - Admission and Length of Stay Certification form authorizing the days of care for which it is billing the Medicaid Program. The claim and form should be submitted to Medicaid's regular billing address.

Prior to admitting a patient to an acute hospital, if the above EVS message is received, the hospital should follow the same procedures it would take for a fee-for-service Medicaid recipient. The hospital must obtain authorization for a non-emergency admission from Medicaid's utilization control agent. After discharge, the hospital should complete the DHMH form 3808 and obtain approval for the length of stay from the agent. This approved form and the bill must be sent directly to the Medicaid Program. It is requested that a copy of the submitted hospital claim also be sent to the MCO for tracking of the services rendered to the recipient. The Program will reimburse the hospital according to Medicaid's rate of reimbursement and recoup the MCO's 10% responsibility from the MCO's capitation payments.

Rare and Expensive Case Management (REM)

Medicaid recipients that are diagnosed with specific conditions are disenrolled from the MCO and enrolled into the Rare and Expensive Case Management program. The following EVS message identifies these recipients:

"Rare and Expensive, call 1-800-565-8190."

Once enrolled in REM, all services are reimbursed directly by the Medicaid Program. For REM recipients, the hospital should follow the same procedures followed for recipients receiving hospital services on a fee-for-service basis.

Questions should be directed accordingly

Billing 1-800-445-1159
Program authorization..... 1-800-999-3362
Stop Loss Program Enrollment Unit..410-767-5445
Stop Loss Program.....1-800-565-8190
Rare and Expensive Program.....1-800-565-8190
Medicaid Policy 410-767-1455

JMM/mcd
Attachment

H. Table of Rare and Expensive Conditions.

Condition Type	Diagnosis	ICD9 Codes	Age Grp
Neonates	Neonatal necrotizing enterocolitis	777.5	<1
HIV Disease	Symptomatic HIV disease (AIDS (pediatric)	042.x all	0-13
HIV positive status	Asymptomatic HIV status (pediatric)	V08	0-13
Inconclusive HIV results	Infant with inconclusive HIV Result	795.71	0-18 mo.
Blood	Aplastic Anemia, constitutional	284.0	0-20
Congen. Anomaly	Multiple congenital anomalies	759.7	0-10
Congen. Anomaly	CNS anomaly, incl. hydrocephalus	742.0, 742.1, 742.3	0-10
Congen. Anomaly	Respiratory system anomalies	748.x all except .9	0-20
Congen. Anomaly	Cleft palate	749 except 749.1x	0-15
Congen. Anomaly	Tracheoesophageal fistula	750.3	0-3
Congen. Anomaly	Specified upper alimentary anomalies	750.7	0-7
Congen. Anomaly	Oth. digest.-atresia large intestine	751.2	0-5
Congen. Anomaly	Oth. digest.-Hirschsprung's, oth colon	751.3	0-15
Congen. Anomaly	Biliary atresia, cystic disease of liver	751.61 and 751.62	0-20
Congen. Anomaly	Other digestive-pancreas	751.7	0-5
Congen. Anomaly	Other digest.-specified and unspec.	751.8 and 751.9	0-10
Congen. Anomaly	Urinary system anomalies	753.x all	0-5
Congen. Anomaly	Musculoskeletal — skull and face bones	756.0	0-15
Congen. Anomaly	Musculoskeletal — diaphragm, other	756.4, 756.5x, 756.6-.7	0-1
Degen. Disease	Extrapyramidal degen. — myocionus	333.2	0-5
Degen. Disease	Cerebral degen. disease of childhood	330.x, all 4th digits	0-20
Degen. Disease	Other cerebral degenerations	331.3, 331.4, 331.89	0-20
Degen. Disease	Spinocerebellar degenerative disease	334.x all	0-20
Degen. Disease	Anterior horn cell disease	335.x all	0-20
Metabolic	PKU, MSUD, oth. amino acid metab.	270.1 thru 270.4	0-20
Metabolic	Urea cycle, oth. amino acid disorder	270.6, 270.9, 271.1	0-20
Rare and Expensive — All ages			
Congen. Anomaly	Spina bifida	741.x all	0-64
Condition Type	Diagnosis	ICD9 Codes	Age Grp
Metabolic	Cystic Fibrosis	277.0, .00, .01	0-64
Metabolic	Histiocytosis	277.8	0-64
Metabolic	Mucopolysaccharidosis, purine dis.	277.2, 277.5	0-64
Blood	Hemophilia	286.0 thru 286.4	0-64
Other	Ventilator Dependent (non-neonate)	V46.1 and V46.9	1-64
Other	Traumatic brain injury (blunt) after 30 day stay in state psychiatric hospital which stay occurred after June 1, 1997 and immediately prior to REM enrollment.	800.x-804.x, 850.2-850.5, 851x-854.x	0-64