

Chapter 10: Retrospective Review Process

A retrospective review by ValueOptions® Maryland takes place under conditions in which consumers become Medicaid (MA) eligible after the delivery of mental health services has been initiated. Cases in which the consumer had active MA at the initiation of services, but the provider did not obtain authorization are not eligible for retrospective review. This review process is completed within 30 calendar days from the day ValueOptions® receives a complete request record from the provider, and is accomplished through a review of the medical record and application of the medical necessity criteria of the Maryland Public Mental Health System (PMHS). Requests for initial retrospective review must be submitted with the medical record for the dates of service in question, along with a cover letter on provider letterhead including:

- Consumer name, MA number, social security number, and date of birth.
- Dates of admission and discharge.
- Dates of service being submitted for review (i.e. any days not covered under courtesy or other insurance).
- ICD-9 discharge diagnosis.
- Level of service being requested.
- Level of request (Initial, Grievance Level I or Grievance Level II).
- Reason authorization was not obtained at time of service.
- Name of provider rendering the service in question.
- Provider's MA number and ValueOptions® Provider Identification Number.
- Name and contact information of provider point of contact to whom the decision can be sent.

The review will be based on medical necessity criteria that address the level of care as well as the intensity of services. The medical record is reviewed by a ValueOptions® Maryland Care Manager (CM) or Physician Advisor (PA). If the CM is unable to authorize any portion of the requested span based on the information provided, the request will be referred to a ValueOptions® Maryland PA for review. The PA's decision is based on the medical record supplied by the provider requesting the review. Any request submitted without a complete medical record may be denied for lack of clinical information. A complete record must include, but is not limited to, the following: patient registration sheet, admission note, discharge summary, progress notes, medication sheets, physicians' order sheets, results of lab and x-rays, treatment plans, aftercare plans, emergency room documentation and the involuntary admission forms, if the consumer was admitted involuntarily. If an incomplete medical record is received, ValueOptions®

Maryland will make a medical necessity decision based on the available information submitted by the provider. The medical record will be retained by ValueOptions® Maryland in accordance with confidentiality standards.

Definitions

A **consumer** is a Maryland Medicaid (MA) recipient, uninsured eligible individual or the consumer's legal guardian who requests mental health services.

A **complaint** is an expression of dissatisfaction with some aspect of the Public Mental Health System (PMHS).

A **retrospective review** is a process available to MA recipients after services for mental health care have been provided if the consumer has retrospective eligibility for those dates of service.

A **grievance** is a process available to MA recipients and uninsured eligible individuals to request a re-review of a non-authorization of requested services for reasons of medical necessity. Consumers can request a grievance or delegate in writing a designee to act on their behalf.

An **appeal** is a formal process available to MA recipients to request the CSA, MHA or Office of Administrative Hearings (OAH) to review the decision.

A **Care Manager (CM)** is a mental health professional responsible for reviewing, coordinating, and approving the mental health treatment of individuals served by the Maryland PMHS.

A **Physician Advisor (PA)** is a board-certified psychiatrist who reviews authorization requests and performs medical necessity determinations.

Clinical service non-authorization is defined as an initial determination by a ValueOptions® Maryland PA that the mental health services requested are not medically necessary.

An **administrative or technical denial** is based on the failure to meet administrative requirements set forth by the PMHS and the MHA, such as following the rules for pre-authorization of services or requesting continued authorization of existing services on or before the last authorized day or service.

An **urgent request** is defined as a request for pre-authorization for admission to an acute inpatient facility, or a service level in which the consumer, or provider of service believes that waiting 24 hours for a decision would potentially be harmful to the consumer.

A **non-urgent request** is defined as a request for continued acute inpatient services or any other service level other than a request for pre-authorization to an acute inpatient admission.

A retrospective review must be requested within twelve (12) months of the Medicaid eligibility decision date in the Maryland Medicaid Information System II (MMIS II). ValueOptions® Maryland will verify eligibility and timeliness of the request prior to proceeding with the clinical review.

The retrospective review process may take place for any service level for which the consumer is eligible to receive services, except for eligible uninsured consumers accessing a purchase of care bed in an acute inpatient facility.

ValueOptions® Maryland can only proceed with a retrospective review of a medical record if there is evidence that one of the following three conditions is met:

- 1) The consumer becomes MA eligible after the initiation of services, retrospectively to cover the dates of service provided. Any dates not previously covered under a courtesy review are eligible for retrospective review.
- 2) The consumer is unable to provide pertinent information upon admission to services. Due to being unaware of eligibility, sharing incorrect information, concerning eligibility, presenting as self pay, or level of consciousness or psychosis at time of admission, the consumer is unable to provide pertinent information upon admission and is later determined to be a MA recipient, or
- 3) An authorization was not obtained because the consumer is eligible for Medicare or commercial insurance, but, during the course of treatment, the consumer's Medicare or private insurance terminated, was exhausted, or otherwise did not cover psychiatric services. Proof of the following is required: 1) exhaustion of the Medicare or commercial benefit, 2) exhaustion of all levels of appeal of any primary insurance carrier, and/or 3) other denial of payment.

If none of the above conditions are met, the provider may appeal directly to the Mental Hygiene Administration.

Failure of the provider to obtain authorization for a consumer that is MA eligible due to weekends, holidays, or other error is not a valid reason for requesting a retrospective review. Providers are responsible for obtaining initial and continuing authorization, either via ProviderConnect or telephonically when MA and uninsured eligible consumers are receiving services. Requests for retrospective reviews will be administratively denied for failure to obtain continuing authorizations, on or before the last authorized day when consumers have active MA or an eligible uninsured span. All requests are reviewed for eligibility and timeliness of submission prior to being reviewed.

Retrospective review decision letters will be sent to the consumer and provider within two business days following completion of the retrospective review. Retrospective reviews are completed within 30 days of the request. Non-authorization letters will include grievance rights.

Claims Submission

Providers should not send a claim form with the medical record, because the claim would then be processed before the retrospective review has been completed. This would result in an automatic denial of payment due to lack of authorization. Providers should wait until they have received a decision letter or a ProviderConnect download from ValueOptions® Maryland before submitting a claim form.

A copy of the decision letter must be attached to a paper claim with “retro-authorization” documented on the paper claim. The claim must be submitted within 12 months of the date of service or 120 days following the grievance decision that results in the authorization of additional days or units. If claims have been submitted for payment previously, all claims rules must be followed. If partial payment was previously made to the provider and additional days or units have been authorized, the original payment will be retracted and the claim will be reprocessed to pay for all the authorized days or units.

Level I Grievance: Retrospective Request

If any portion of an initial retrospective review request has been denied for services, a Level I Grievance can be requested by either the consumer or the provider acting on behalf of the consumer. Requests must be made within 10 business days of the date of the initial decision letter, and review of Level I Grievances will be completed within 15 calendar days of the grievance being filed.

- Level I Grievance requests from the consumer are accepted verbally at 1-800-888-1965, option 3. ValueOptions® Maryland will document the request on behalf of the consumer.
- Providers requesting a Level I Grievance must present the request in writing and include the following information in a separate cover letter. The cover letter is considered part of the medical record and must include the following information:
 - Statement documenting the level of grievance being requested and the Authorization/Tracking Number found on the notification of non-authorization. Attaching a copy of an initial non-authorization is also recommended.
 - Consumer’s first, middle and last name
 - Consumer’s Medicaid identification and/or Social Security number
 - Consumer’s date of birth
 - Level of service requested (inpatient, PHP, RTC, etc.)
 - Admission date, discharge date, specific dates of service to be reviewed
 - Provider/program/facility name
 - Medicaid provider number

- ValueOptions® Maryland Provider Identification Number
 - Mailing address
 - First and last name of provider contact, title, phone number, and e-mail address
- It is not necessary to submit another copy of the medical record unless requested to do so, or new information is available or requested to support the Level I Grievance. The original medical record submitted for the initial retrospective review will be used for the Level I Grievance.
 - If a complete medical record was not previously submitted, the provider will send a copy to ValueOptions® Maryland. As previously stated, the medical record must include, but is not limited to, the following: patient registration sheet, admission note, discharge summary, progress notes, medication sheets, physicians' order sheets, treatment plans, results of labs and x-rays, aftercare plans, emergency room documentation and the involuntary admission forms, if the consumer was admitted involuntarily. If an incomplete medical record is received, ValueOptions® Maryland will make a medical necessity decision based on the available information submitted by the provider.
 - All Level I Grievances are reviewed by a Maryland PA
 - If the ValueOptions® Maryland PA concludes that services are medically necessary, ValueOptions® Maryland authorizes the requested service and forwards a Level I Grievance authorization letter to the consumer and the provider within two business days of the decision. The authorization is also entered in ProviderConnect and is available to the provider via download.
 - If the ValueOptions® Maryland PA concludes that the non-authorization or partial non-authorization is appropriate, a Grievance Level I non-authorization letter that includes the next level of grievance available to the consumer will be forwarded to the provider and consumer within two business days of the decision.

Level I Grievance requests may be submitted via:

Mail: ValueOptions® Maryland
 Attn: Grievances
 1099 Winterson Road, Suite 200
 Linthicum, MD 21090
 Fax: 877-381-5571

E-mail with encryption or password protected patient health information:

Grievances@valueoptions.com. An e-mail confirmation will be generated back to the provider when using electronic filing of the Level I Grievance request.

Level II Grievance: Retrospective Request

If any portion of the retrospective review is denied on a Level I Grievance, a request for a Level II Grievance can be submitted within 3 business days of the Level I Grievance. A Level II Grievance will be completed by ValueOptions® Maryland within 15 calendar days of the grievance being filed.

- Provider requests for Level II Grievance must be in writing and include the following information:
 - Statement documenting the level of grievance being requested and the Authorization/Tracking Number found on the notification of non-authorization. Attaching a copy of an initial non-authorization is also recommended.
 - Consumer's first, middle and last name
 - Consumer's Medicaid identification and/or Social Security number
 - Consumer's date of birth
 - Level of service requested (inpatient, PHP, RTC, etc.)
 - Admission date, discharge date, specific dates of service to be reviewed
 - Provider/program/facility name
 - Medicaid provider number
 - ValueOptions® Maryland provider identification number
 - Mailing address
 - First and last name of provider contact, title, phone number, and e-mail address
- The original medical record submitted for the initial retrospective review will be used for the Level II Grievance. Do not submit another copy unless requested to do so, or unless new information is now available for the Level II Grievance.
- If the ValueOptions® Maryland PA concludes that services are medically necessary, ValueOptions® Maryland authorizes the requested service and forwards a Level II Grievance authorization letter to the consumer and the provider within two business days of the decision. The authorization is also entered in ProviderConnect and is available to the provider via download.
- If the ValueOptions® Maryland PA concludes that the non-authorization or partial non-authorization is appropriate, a Grievance Level II non-authorization letter that includes the next level of appeal available to the consumer will be forwarded to the provider and consumer within two business days of the decision.

Level II Grievance requests may be submitted via:

Mail: ValueOptions® Maryland
Attn: Grievances
1099 Winterson Road, Suite 200
Linthicum, MD 21090

E-mail with encryption or password protected patient health information:

Grievances@valueoptions.com. An e-mail confirmation will be generated back to the provider when using electronic filing of the Level II Grievance request.

Level III - CSA Appeals

When the consumer does not agree with the determination made by the ValueOptions® Maryland PA following the Level II Grievance, the CSA Director of his/her county of residence may be contacted to appeal the decision. Appeals will be completed and the decision communicated to the consumer and provider by the CSA within 10 business days of the request.

Process for Level III Appeals:

- Within 10 business days of the Level II non-authorization, a Level III appeal to the CSA of the county in which the consumer resides may be initiated.
- When requested, ValueOptions® Maryland will forward to the CSA all the documentation regarding the decision within one business day.
- The CSA may contact the appropriate provider for any additional information needed to re-evaluate medical necessity.
- The CSA may request that the consumer or provider follow the grievance process with ValueOptions® Maryland if he/she has not already done so.
- When the CSA authorizes services, they will inform the consumer and the provider, telephonically, of the determination within one business day. The CSA will notify ValueOptions® Maryland, MHA, and the provider, in writing within two business days, of the decision, using the approved form letter which must be signed by the Physician Advisor.
- When the CSA decides to uphold ValueOptions® Maryland non-authorization, the CSA must inform the consumer and provider by phone or fax within one business day of the decision. The CSA will notify ValueOptions® Maryland, MHA, and the provider, in writing within two business days, of the decision, using the approved form letter which must be signed by the Physician Advisor.

- Consumers must also be informed by the CSA of their right to appeal to the Mental Hygiene Administration.

Level IV - MHA Appeal

- Regarding appeals submitted for MHA review:
- Appeals must be submitted in writing to MHA within five business days after receipt of a CSA's decision.
- MHA may perform an investigation of the appeal, which must be accomplished within 10 business days.
- MHA may refer the appeal to either ValueOptions® Maryland or the CSA for re-review when grievance levels have not been utilized.
- MHA must make its determination and provide written notification to the consumer within 15 business days.
- Medical Assistance (MA) recipients will be informed by the MHA of the right to appeal to the OAH.
- The MHA is the final authority for consumers who are uninsured eligible.
- MHA will notify ValueOptions® Maryland, in writing, of any appeal that results in an authorization.

To file a Level IV Appeal with the MHA via mail:

Attn: Grievances and Appeals
Mental Hygiene Administration
Spring Grove Hospital Center-Dix Building
55 Wade Avenue, Catonsville, MD 21228

Level V – OAH Appeals

If a consumer with MA wishes to appeal the MHA's decision, he/she must file a notice, in writing, to the Office of Administrative Hearings (OAH) within 45 business days of MHA's decision to not authorize services.

Requests for appeal hearings should be submitted via mail to:

Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301
Voice: (410) 229-4100, Fax: (410) 229-4111

Administrative Denials

Administrative denials most frequently occur when:

- 1) The provider fails to obtain preauthorization
- 2) Timely filing requirements are not met
- 3) Services are provided by a provider who is not participating in the primary coverage carrier's network.
- 4) The consumer is not a Medicaid beneficiary
- 5) The consumer was admitted to a medical unit or for a primary medical diagnosis, including substance abuse. This must be appealed directly to the consumer's Managed Care Organization (MCO).

Administrative denials may be appealed to the Mental Hygiene Administration (MHA) when the claimant believes that an exception to Medicaid rules is justified.

To file an Administrative Appeal with the MHA via mail:

Attn: Administrative Grievances
Mental Hygiene Administration
Spring Grove Hospital Center – Dix Building
55 Wade Avenue
Catonsville, MD 21228

Administrative denials may be appealed to ValueOptions® Maryland if, and only if, the claimant believes the administrative denial was due to an error on the part of ValueOptions® Maryland.

To file an Administrative Appeal with ValueOptions® Maryland via mail:

ValueOptions®
Attn: Claims Appeals Dept.
P.O. Box 1950
Latham, NY 12110