MA Problem Resolution Division - FAQ's

1) What are the responsibilities of the MA Problem Resolution Division?

The MA Problem Resolution Division is a liaison between the Maryland Department of Health (MDH) and its participating institutions/facilities. The MA Problem Resolution Division representatives collaborate with other MDH/DHS departments to assist with investigating, aiding, responding and or resolving institutional/facility claims payment related issues (UB04 billing related to coding, claims status, denials etc.). The Division is comprised of two units that operate and function separate:

- **The MA Long Term Care Medical Assistance Problem Resolution Unit (MA LTCPRU),** primarily handles LTC span related denials resulting from eligibility and/or 257 issues causing claims denials. Please note that the LTCPR Unit does not process or accept UB04 hardcopy claims or non-span related denial issues for review or payment.

- **The MA Problem Resolution Unit (MAPRU/UB04),** primarily assists providers with claims status and questions concerning problem claims (i.e. billing policies and procedures, coding, statute, eligibility etc.). Please note that the UB04/MAPRU does not accept 257 and/or span inquiries for review or processing.

2) How do I submit a claim?

- **Normal** (current dates of service):
  Claims Processing Division
  PO Box 1935
  Baltimore, MD 21203

- **Problem claims** (errors, timely filing , etc.) should be sent with a cover letter explaining the problem to:
  MA Problem Resolution Unit (UB04)
  PO Box 1935, Rm SS-5
  Baltimore, MD 21203

3) Who should I contact if I have questions concerning outstanding or denied claims?

- For **LTC span** related denials you may email a LTCPRU inquiry to mdh.ltcmapr@maryland.gov or call 410-767-8699.

- For **status or problem claims** (coding errors, denials and questions) contact the MA Problem Resolution Unit (UB04) at 410-767-5503/1-800-445-1159 (option 3) or 410-767-5457

4) How long does it take to resolve problems or what's the turnaround response time?

For both Units within the MA Problem Resolution Division:

- Problems are normally resolved within 30-60 days of receipt.

Note: *More complex inquiries require further review and usually have a longer turnaround time due to additional handling needed or required.*

5) What is the timely filing statute for claims?

- Invoices for institutional services must be received within twelve (12) months of the date of discharge or date of service.
- If a claim is rejected because of late receipt, the patient cannot be billed for that claim.
- Claims with dates of service over the 12 month statute will not be for overridden for timely filing unless one or more of the guidelines listed below is met:
  - The recipient was certified for retroactive Medicaid benefits.
  - The recipient won an appeal in which he/she was granted retroactive Medicaid benefits, and/or;
  - The failure of the claim to pay was the Program's fault, each time the claim was adjudicated.
- If a claim is received within the 12 month limit but rejected, resubmission will be accepted within 60 days of the date of rejection or within 12 months of the date of discharge (or month of service if chronic), whichever is the longer period.
- Timely filing will only be taken into consideration for circumstances that support claims received within the 12 month limit but rejected with a resubmission acceptance within an every 60 day re-submission from the date of rejection or within 12 months of the date of discharge. Contact should be made to the **MA Problem Resolution Division** within a reasonable time frame (12 months from the date of service) to prevent non-payment for resolution of errors.

Note: ***The 60 day re-submission process is a component of the timely filing rule/statute. Timely filing will not be overridden in circumstances in which there is continuous billing/resubmission every 60 days when the error is resulting from the providers failure to follow billing policies and procedures and/or the inability to correct the billing error(s) identified by the Program.***

6) How can I check recipient eligibility?

The Program recommends that a provider check recipient eligibility consistently (daily) for any type of Maryland Medicaid benefits, please use the Eligibility Verification System either by dialing 1-866-710-1447 or visiting website www.emdhealthchoice.org

7) How can I see the status of my claims?

Status of claims can be reviewed on eMedicaid at www.emdhealthchoice.org.
This is a secure website using your individual login ID and password. Please go to the site and follow the prompts or call 1-800-445-1159 (option 3) or 410-767-5457 for assistance.

8) Will I get priority preference for previously submitted information/documents that were submitted for review?

The Division considers all of our providers and submitted inquiries to be a priority. All information/documents received are processed in the date order received. We are unable to give priority to previously submitted inquiries due to the high volume of provider inquiries,

limited staff, unit commitments and responsibilities as expedient turnaround time may not be available.

9) How do I resolve LTC span related issues?

LTC span related issues/denials should be forwarded to the LTCPRU by fax, mail, or email to the address noted:

Please submit a span inquiry with the noted details/documents below the unit at mdh.ltcmapr@maryland.gov.

The spreadsheet must include: the 9 digit provider ID#, submission date, facility name, Recipient/MA ID#(s), DOS (from & through dates mm/dd/yy), Claim denial code, comment/notes, contact name telephone #, fax #, and email address with the following information:

- Applicable 257 (facility info, recipient info, correct begin/cancel information, Telligen level care certification info. For each patient)
- Applicable and corresponding co-insurance worksheet (check dates)
- Applicable and corresponding Medicare EOB
- Applicable and corresponding private insurance remit/EOB (check dates and amounts)
- Notice of Eligibility (4233)
- Notice of change of income (4240)
- Certified Death Certificate

10) How will I be notified of the receipt/status of my inquiry?

For both MA Problem Resolution Units, providers are provided notification of inquiries once the inquiries are completed. Notification can come in the form of a span correction/update being done, claim processed or by a notice sent from a LTCPR Specialist, or UB04 PRU Representative.

11) What is a 257 and when is it required?

The DHMH 257 entitled" Long Term Care Activity Report" is a multi-functional form required by the Program to be used by nursing home and chronic facilities to track and report individual patient stay transactions (i.e. full Medicaid, Medicare co-insurance, date of discharge, etc.) and the UCA level of care certification period resulting from a medical eligibility review. .

12) Who is the current Utilization Control Agent (UCA) for Maryland?

Telligin is Maryland Medicaid's Utilization Control Agent and they determine the level of care for nursing, chronic and specialty hospital services by completing medical eligibility reviews (MER), or continued stay reviews for both approved and pending MMA recipients.

13) When is a level of care authorization (LCA) needed on the MDH 257 form?

- To certify medical necessity to begin full MA
- Community Coverage/less than 30day stay under Full MA
- Revoking Hospice to return to skilled nursing/chronic level

14) Can I submit a 257 reflecting presumptive Medicare coinsurance dates?

Only valid coinsurance dates must be reported on the 257 as determined/due by Medicare or by the applicable patients' primary insurance. Submitting presumptive dates for span processing may conflict and prohibit access or provider payment denials with other available community and special program services prior to a nursing or chronic stay, as well as to avoid dual/duplicate agency payments.

Note: *The Required documents for 257 coinsurance stays/request are:*

- *Medicare EOB (Medicare/Medicare Advantage Plan)*
- *Coinsurance worksheet*

15) Can I submit patient UB04 bills and span corrections together?

The LTCPRU does not accept UB04 bills/hardcopy claims in the place of information/documentation required in item #10 to resolve span corrections.

UB04 hardcopy claims must be submitted to Claims Processing and/or to UB04 PRU as noted in item# 2.

16) How should I resolve a LTC and MCO conflict?

The Long Term Care Problem Resolution Unit (LTCPRU) does not authorize MCO enrolment or disenrollment. Please contact the **MDH HealthChoice Long Term Care Disenrollment Unit** at:

201 W. Preston Street, Room L9
Baltimore, Maryland 21201
Phone: 410-767-5321
Fax: 410-333-7141

17) How do I complete a 257 for a patient having a Medicare Co-insurance stay?

The most prevalent 257 errors occur when submitting Medicare coinsurance 257 documents. Please see the instructions below to assure that your documents are completed correctly:

If Community Coverage/Less than 30-day or up to 80-day Medicare Coinsurance stay

The nursing facility must complete a DHMH 257 Form and obtain a UCA certification sign-off and complete the 257 as follows:

- Section "A. Begin Payment:"
  - #2 Medicare A co-payment (must enter both Begin pay date and End pay date)
- Section "B. Cancel Payment:"
  - You must report the discharge status

If LTC Coverage/Medicare Coinsurance to Full MA

- Section "A. Begin Payment:"
  - #1Full MA coverage (must include a begin date)
  - #2 Medicare A co-payment (must enter both Begin pay date and End pay date)

Note:

- *To begin full MA, a DHMH 257 must be signed by UCA for level of care certification.*
- *In Section A. Begin Payment, any "end pay date" entered must be equal to the discharge date reported in Section B or must be equal to the full MA begin pay date reported in Section A.*
- *Section B. Cancel Pay should not be completed until a patient permanently discharges from your facility.*

18) How do I complete a 257 for a "less than 30-Day Full MA Stay?"

- Section "A. Begin Payment:"
  - #1 Full MA coverage (must include a begin date)
- Section "B. Cancel Payment:"
  - You must report the discharge status
  - If the patient has not been discharged from your facility, the DHMH 257 will be returned for completion of LTC application and conversion of eligibility coverage to LTC.

Note: The 257 form must be certified by the UCA.

19) When is a DHS (DHR) IMA 81 letter issued?

IMA-81 letter-s is normally issued under the following circumstances:

- Recipient was certified for retroactive Medicaid benefits.
- The recipient won an appeal in which he/she was granted retroactive Medicaid benefits, and/or;
- An agency error or delay has occurred during an eligibility determination, or case resolution.

Note:

- *An IMA-81 letter-s will only be issued to override timely filing for older service dates if it has been determined by the LDSS case manager or by the LTCPRU that it was an agency error or delay that occurred during an eligibility determination, or case resolution.*
- *Please also refer to item #5 timely filing billing statue and circumstances required to support validity for an IMA 81 letter.*

20) How do I complete transfers to another facility?

You must report your cancel pay/discharge date in Section B of the DHMH 257 Form.

Note: *the* ***discharge date from the prior facility must match the begin date*** *into the new facility). The span end date will be the date prior to the date of discharge reported with the admit date into the new facility being the first billable date of service.*

21) How do I complete a 257 for a patient who resides in our facility but has elected the Hospice benefit?

It is not necessary for a nursing home to submit a discharge 257, as the MDH Hospice Unit will end nursing home spans after coordination and verification with the Hospice provider to identify and process hospice elections on MMIS.

22) What do I do if the patient elects the hospice benefit but decides to revoke their hospice benefit?

The nursing facility must complete a DHMH 257 Form and obtain a UCA certification. . Complete the 257 as follows:

Section "A. Begin Payment:"

- #4: Revocation of Hospice care and return to NF care - fill in effective date.
    - Hospice Revocation/Termination Form is also required (per DHMH/MDH Nursing Home Transmittal No. 208)
- Both forms must be submitted to the MA LTC Problem Resolution Unit.

Note: *The effective date should be the hospice actual discharge date and the nursing home actual begin pay date. These dates should match/equal. Also, a LTC PRU return notice may be sent requesting a copy of the hospice termination/revocation form..*

23) Is it necessary to submit multiple 257's when my patient changes levels (from Medicare coinsurance to Full MA or Full MA back to Full MA Medicare?

From the initial Medicare coinsurance begin and conversion to Full MA will the nursing facility complete a DHMH 257 form reflecting both pay types and obtain a UCA certification sign-off. The 257 must be completed as follows:

Section "A. Begin Payment" by checking all that apply:

- #1Full MA coverage (must include a begin date)
- #2 Medicare A co-payment (must enter both Begin pay date and End pay date)

Once full MA LTC spans are established in MMIS for your facility through an ongoing stay/period , it is not necessary for you to send a DHMH 257 form when the patient reverts back to full Medicare, and then to full MA again.

Note: *When billing, make sure your facility does not submit claims for full Medicare dates of service.* ***The only time another 257 is needed is when the patient discharges from your facility due to death, discharge to community, or a transfer to another facility.***

24) When should I complete a 257 to report a CANCEL pay in Section B?

If your patient leaves your facility for the below reasons:

- Discharge to community
- Transfer to another facility
- Death

Note: *It is imperative that the LTC facilities submit the cancel pay information on the 257 forms (Section B. Cancel Payment). Lack of cancel pay documents cause denial of community services and disruption to continuity of care for the patient.*

25) Why has my 257 been returned by the LTC Problem Resolution Unit?

The 257 was returned because:

- Medicare coinsurance remit/EOB missing

- Missing or incorrect coinsurance worksheet
- No level of care obtained from UCA
- Missing patient or provider demographic information (MA #, SS#, discharge date, facility name etc.)
- Incorrect level of care obtained (Chronic facility with level of care marked as nursing facility)
- Recipient has no eligible coverage

26) My claims are continuing to deny for 281 (LTC Recipient & Provider not linked for DOS billed) or 211 (LTC span does not cover dates of service billed) after my spans have been corrected, why?

- Check to ensure proper billing procedures have been followed
- Check to ensure that the 257 begin pay and subsequent from and through dates matches service dates billed
- Check to ensure dates of service billed does not include a non-billable patient discharge date
- Review and Check to ensure that the most current/recent remittance advice reflects the most current denial
- Check the remit reported EOB denial codes and explanations on the most current/recent remittance advice(s) to identify whether the denial is a LTC span related issue or claims billing related denial and contact the applicable unit as stated in question #2 for resolution.

27) How do patients transfer over when there is a change of ownership (CHOW)?

Once an approval is granted from the from the MDH Office of Health Services Administration a notification is submitted to the Long Term Care Resolution Unit to initiate patient transfer in both CARES and MMIS.

The MA LTC Resolution Unit will send an email to the new facility administrator and/or appointed business office personnel requesting an encrypted/password protected excel spreadsheet listing with all eligible Medicaid recipients residing in the facility. The list should include: old provider #, the new provider #, new effective date, patient name, patient MA #, SSN and date of birth for residents with active ongoing coverage who resided in the prior (old) facility and are currently residing in the new facility after the change of ownership.

Residents who have discharged, expired, pending or disenrolled/no longer eligible prior to the change of ownership should not be included on the listing, if listed the CHOW updates cannot be completed.

The new facility administrator and/or appointed business office personnel will be contacted via email once the patient listing has been completed and of any issues preventing recipient updates that may require further review.

Note:

- The process of transferring the provider numbers for each recipient is manual.

- The administration will allow a one-time only waiver of the initial certified begin 257 which is required to verify each patients' prior providers' nursing stay.
- Patient transfers are normally processed within 2-3 business days (processing time may vary due to the number of recipients reported or if there are multiple facilities approved for a simultaneous CHOW's).
- Failure to follow the above will result in claims denying

28) What if I have patients pending MA or reconsideration during a change of ownership?

Patients with pending MA, or overdue reconsiderations should not be sent to the LTC Problem Resolution unit until coverage becomes approved.

Once coverage becomes approved, the facility should send a spreadsheet with the patients name, recipient ID # , SS#, and date of birth to include copies of the applicable 257 and current notice of eligibility (NOE) for processing.

29) **What is a 206C and how is it used?**

A 206C document is an internal correction form utilized by the LDSS case managers and State Medicaid staff only and is forwarded to the OES DREP Unit to make necessary span updates/corrections to the MMIS II provider file when the normal automated system data transfer process from CARES to MMIS II fails with system updates. The 206C cannot be used or requested in place of the normal automated system process.

30) How do I update my CARES private daily room rates?

To update facility private daily room rates you must access the Long Term Care/Chronic Facility Rate/Change Form on the MDH website under Billing Instructions, the MDH link: https://mmcp.health.maryland.gov/Pages/Billing-Instructions.aspx, or call 410-767-8699.

Note: *A Long Term Care/Chronic Facility Rate/Change Form must be submitted each time the private daily room rates change.*