



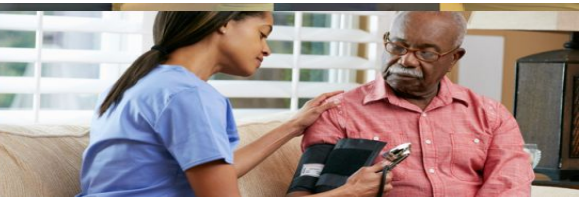
Chronic Hospital Review Process Changes

Office of Long Term Services & Supports

Office of Medical Benefits Management

Office of Medicaid Provider Services

May 17, 2023



Agenda

- Introductions
- Background
- Processes that will not Change
- Summary of Changes
- Transition Timeline
- Submissions to Qualitrac
- Qualitrac Details

Introductions

Background

- Maryland Medicaid is requiring that all providers enrolled as Chronic Hospital (Provider Type 05) enroll as a Special Other Acute Hospital (Provider Type 06).
 - Special Other Acute Hospital providers will be reimbursed without having to obtain a long term care (LTC) span for Medicaid participants using a form 257.
 - Providers will instead use the retrospective 3808 process for billing authorizations.
 - This change aligns Medicaid practice with previous regulatory amendments that removed the necessity for Chronic Hospitals to obtain a LTC span for Medicaid participants.
- Providers are still required to obtain initial and continued stay review (CSR) Level of Care determinations for participants, but authorizations for billing will now be through the retrospective 3808 process.

Processes that will Not Change

- Providers must continue to submit Initial and Continued Stay Review (CSR) level of care requests to Telligen through Qualitrac.
- Providers will continue to use the “Adult Chronic” review type in Qualitrac and complete the 3871B questionnaire.
- Level of care requests must be submitted with the proper documentation which, at a minimum, includes:
 - History and Physical
 - Most recent progress notes
 - Labs
 - Imaging results
 - Physical, occupational, and other therapy notes
- Providers will continue to adhere to the same (CSR) frequency requirement, i.e. request a CSR no later than 30 days after admission or Medicaid conversion, then every 14 days thereafter.

Summary of Changes

- Providers are no longer required to receive a certified form 257 for billing.
- Providers will no longer submit 257 span requests to LTCPRU.
- Coinsurance claims will also no longer require a certified 257. There is no comparable replacement step or authorization requirement under the 3808 process.
- Providers will use the retrospective 3808 authorization process for billing.
- Providers will now receive an 8-digit authorization number. This number is provided by Telligen via Qualitrac following the level of care approval and a 3808 retrospective review of services. The authorization number is necessary for billing.

Summary of Changes (continued)

- Providers may submit 3808 retrospective requests as frequently as they would like for billing, prior to or after discharge, as long as the hospital has an approved level of care covering the period on the 3808.
- Interim billing would require multiple 3808 requests, each for the specific dates of service.
- Providers have one-year from the date of service to submit their 3808 for billing.

Transition Timeline

February 10, 2023	Maryland Department of Health issued Chronic Hospital Transmittal No.4
March 1, 2023	Providers able to submit an application under their existing business profile as a Special Other Acute Hospital (Provider Type 06).
April 15, 2023	Ideal application submission deadline. If your agency has not already submitted an application, please enroll via ePREP (health.maryland.gov/ePREP), or contact the Provider Services Call Center at 410-767-5457.
May 31, 2023	End date of Chronic Hospital profiles (Provider Type 05)
June 1, 2023	Start date of new Special Other Acute Hospital provider type 06 profiles & cutover to 3808 submission process.

Submission to Qualitrac

There are two types of reviews necessary to successfully bill for Chronic Hospital services:

1) Initial and CSR requests:

- These requests are still required
- Entered as Review Type “Adult Chronic” in Qualitrac (no process change)
- Timing entered as Prospective and/or Concurrent for Initial and “Continued Stay Review” for CSR requests
- Medical eligibility criteria have not changed
- No form 257 necessary

2) Retrospective 3808 requests (new):

- Requests should be entered only if an initial or CSR approval covers the dates of interest.
- Entered as Review Type “Acute Medical Surgical” & “Retrospective” Timing in Qualitrac
- Medical necessity criteria used (Milliman Care Guidelines or MCG)
- Once approved, receive an authorization number for billing



Concurrent & Continued Stay Reviews



Review Type

Select the type of review you are requesting

For this review you will select the following:

- **Adult Chronic**
- **Pediatric Specialty**

Review Type *

▼






- Acute Medical Surgical
- Adult Chronic
- DME
- Home & Community Based Review
- Home Health Care
- Medical Surgical (Outpatient)
- Nursing Facility
- Pediatric Specialty
- Procedures



Authorization Request Panel

- **Place of Service** is where the care is being given
- **Type of Service** is what type of care is being provided
- **Timing** is where you will select Prospective (Prior Authorization) or Concurrent.

Authorization Request

Date Request Received *	Review Type *	Place of Service *	Type of Service *
04/27/2023 02:01 pm 	Adult Chronic 	Skilled Nursing Facility 	Skilled Nursing Facility Ventilator Level of C 
Timing *			
Concurrent 			
<input type="checkbox"/> Is this Request Urgent?			
			<div>Cancel</div> <div>Add New Request</div>



Timing





- **Prospective** – A review request submitted prior to services starting or before any type of inpatient stay – *These usually are reviews submitted by acute care providers*
- **Concurrent** – A review request submitted if services have started or the member is in a facility for a stay that was not prior authorized or the acute facility did not provide visibility to the case.
- **Continued Stay** – A review request used to extend a member's stay on a previously submitted prospective or concurrent review. Continued Stay cannot be the first review timing submitted.



Provider Organization Visibility

- To ensure all applicable organizations have access to the review in the Qualitrac system, please select the organization or facility in the Provider Organization Visibility panel.

Providers *

Type	Name	NPI	Address	Phone	Primary Taxonomy	PPO Redirect Reason	Comments	Action
Treating Physician	 BARTICK, MELISSA	1841213824	Cambridge Health Alliance 1493 Cambridge Street Cambridge, MA, 02139	(617) 665-1000	Hospitalist			 Remove
Treating Facility *				Not Supplied				 Add
Ordering Provider *				Not Supplied				 Add

Provider Organization Visibility ?

BARTICK, MELISSA, Treating Physician

Provider, Maryland, User *



- If you have submitted a Prospective or Concurrent review request and now need to ask for additional days, you can search for that review in the **Member Hub**, click on the ellipsis to the right of the review and select **Continued Stay Review**

Utilization Management										View Cases	+ Add
Show 10 entries										Search: <input type="text"/>	
Status	Case ID	Request ID	Review Type	Timing	Treating Prov./Phys.	Treating Facility	Req. Start	Req. End	Outcome	Action	
Request Has Been Submitted	3242	3254	Nursing Facility	Prospective	MINU, ITTOOP	ASSISTED SHUTTLE LLC	02/20/2020				...
Showing 1 to 1 of 1 entries											
										<div>View Request</div> <div>Delete</div> <div>Continued Stay Review</div>	



- After clicking **Continued Stay Review** in the action menu, a modal will open.
- The modal will confirm that you want to submit a continued stay review. If so, select **Request Extension**.

A screenshot of a web modal dialog titled 'Continued Stay Request' with a close button (X) in the top right corner. The main text inside the modal asks, 'Are you sure you want to request an extension for this request?'. At the bottom right of the modal, there are two buttons: a white 'Cancel' button and a green 'Request Extension' button.

Continued Stay Request

Are you sure you want to request an extension for this request?

Cancel Request Extension

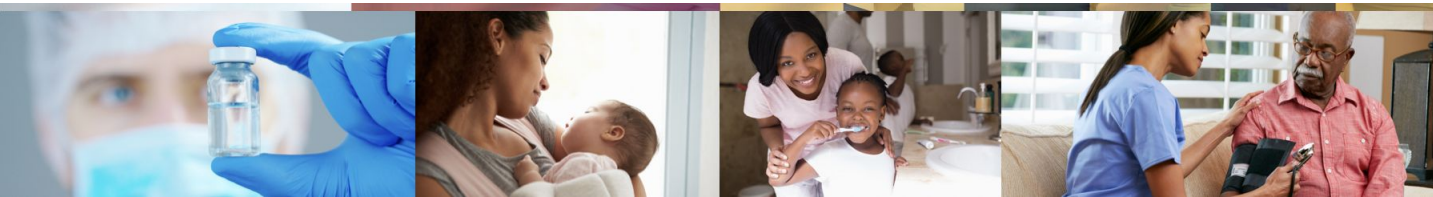


Finalizing the Review

- Click the **Submit Request** button to finalize the review.
- **The system will copy all information from the Prospective/Concurrent review.**
- You will then add clinical documentation to the review to support the continued stay request.
- Submit the review to Telligen
- Additional CSR reviews can be submitted in this way until the member is discharged from the facility.



3808 Submissions



3808 Submissions

- New Review type for most of you
- Replaces the 257
- The timing of these submissions will always be RETROSPECTIVE.
- You can bill while the patient remains inpatient.
- The admission and discharge dates will be the dates for the timeframe you are billing.

- For **Acute reviews** with Retrospective Timing, you will next enter the following:
 - Admission and Actual Discharge Date
 - Admin Days – **leave blank**
 - Length of Stay - calculated for you using the Admission and Discharge dates
 - Admission Type –
 - Admission Source – select from the drop-down options
 - Discharge Disposition – select from the drop-down options
 - DRG

NOTE: Items marked with the red asterisk * are required, others are optional

Admission and Discharge			
Admission Date *	Actual Discharge Date *	Admin Days	Length Of Stay
<input type="text" value="06/10/2019"/>	<input type="text" value="06/17/2019"/>	<input type="text" value="2"/>	<input type="text" value="7"/>
Admission Type *	Admission Source	Discharge Disposition *	DRG
<input type="text" value="Urgent"/>	<input type="text" value="Emergency Room (ER)"/>	<input type="text" value="Discharged to home/self care 'routine ch'"/>	<input type="text"/>

Coverage Panel

- The Coverage Panel will display information about the member's coverage and eligibility.
- The Medicare Indicator and Third-Party Liability information will default to No/Not Supplied unless there is information in our system as provided in the State eligibility file.

Coverage

⚠ Member Not Eligible
The member does not meet eligibility requirements. Please provide a reason to explain why you are continuing with this authorization request.

Show **10** entries Search:

Group	Section	Plan	Start Date	End Date
No data available in table				

Showing 0 to 0 of 0 entries Previous Next

Medicare Indicator ^{*}
Both Part A and Part B






Third Party Liability ^{*}
No

Eligibility Comment ^{*}

Entering Physician and Facility Information

- The physician or facility information will populate in the corresponding panel.
- If the ordering provider is the same as the treating physician or the treating facility, you can select **Copy**, to quickly populate that information.
- You can select **Remove** if you've made a selection in error.


Providers *


Type	Name	NPI	Address	Phone	Primary Taxonomy	PPO Redirect Reason	Comments	Action
Treating Physician	 BARTICK, MELISSA	1841213824	Cambridge Health Alliance 1493 Cambridge Street Cambridge, MA, 02139	(617) 665-1000	Hospitalist			 Remove
Treating Facility	 BLACKWATER MEDICAL ASSOCIATES LLC	1508986092	Clinic # 00 408 Byrn Street Cambridge, MD, 21613	(410) 228-1068				 Remove
Ordering Provider *	Not Supplied							 Add

Provider Organization Visibility ⓘ

BLACKWATER MEDICAL ASSOCIATES LLC, Treating Facility

+ Add New





 Copy Treating Physician to Ordering Provider

 Copy Treating Facility to Ordering Provider

Provider Organization Visibility

- To ensure all applicable organizations have access to the review in the Qualitrac system, please select the organization or facility in the Provider Organization Visibility panel.

Providers *

Type	Name	NPI	Address	Phone	Primary Taxonomy	PPO Redirect Reason	Comments	Action
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Treating Facility *				Not Supplied				 Add
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Provider Organization Visibility ?

BARTICK, MELISSA, Treating Physician

Provider, Maryland, User *

Diagnosis

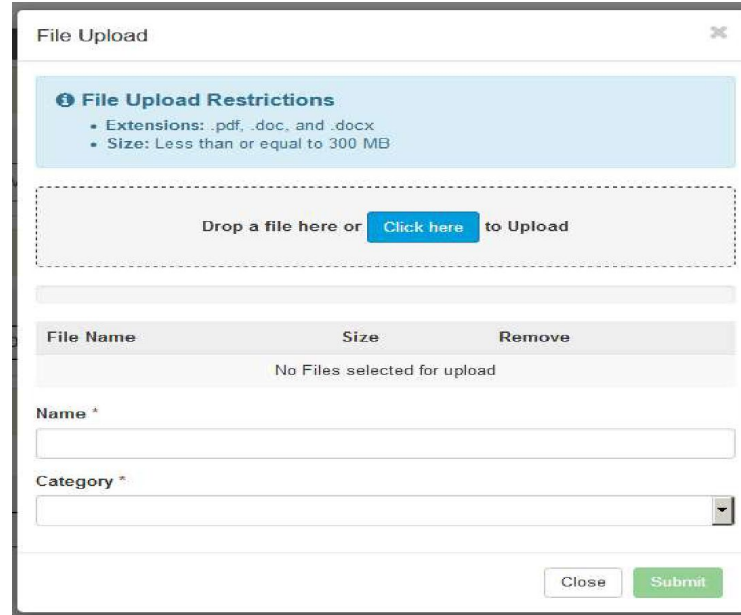
- The Diagnosis Panel is where you enter the diagnosis information related to this review.
- You will use the [Add](#) button to add a new diagnosis to the panel.
- You can enter as many diagnoses as needed.

Diagnosis + Add

Seq.	Code	Description	Final Dx	POA	NOS	Action
No Diagnoses Supplied						

Documentation Panel

- When you click the [Add](#) button on the Documentation Panel, a modal will open where you can drag and drop files or select [Click here](#) to open a windows directory and find the necessary files.
- Documents must be in PDF or Word format.
- The file name cannot contain spaces or special characters.
- The name of the document can be edited in the Name box as applicable.



The image shows a 'File Upload' modal window. At the top, it says 'File Upload' with a close button. Below that is a section titled 'File Upload Restrictions' with two bullet points: 'Extensions: .pdf, .doc, and .docx' and 'Size: Less than or equal to 300 MB'. In the center, there is a dashed box containing the text 'Drop a file here or' followed by a blue button labeled 'Click here' and the text 'to Upload'. Below this is a table with three columns: 'File Name', 'Size', and 'Remove'. The table is currently empty, with the text 'No Files selected for upload' centered below the headers. Under the table, there are two input fields: 'Name *' and 'Category *'. At the bottom right, there are two buttons: 'Close' and 'Submit'.

File Name	Size	Remove
No Files selected for upload		

Name *

Category *

Close Submit

Documentation Panel

- Category allows you to select the type of document you are attaching. This will most always be clinical.
- Topic further defines the type of clinical information you are attaching.
- Click [Upload](#) to attach the information to the review.
- This can be repeated as many times as necessary to attach all relevant documentation to your request.

File Upload

File Upload Restrictions

• Extensions: .pdf, .doc, and .docx

• Size: Less than or equal to 300 MB

Drop a file here or [Click here](#) to Upload

File Name	Size	Remove
sample health record.docx	12 KB	

Name *

sample health record

Category *

Clinical

Topic *

Medical & Treatment History

Close

Upload



Documentation Panel

- When all the request steps have been completed, click [Continue](#) at the bottom right corner of the page.

Documentation

Search:

Name	Category	Topic	Date Added	Uploaded By	Action
sample health record	Clinical	Medical & Treatment History	07/06/2019	swilsonPPU	<div></div>

Show 10 entries

Showing 1 to 1 of 1 entries

Previous

1

Next

Continue



MCG

- Patient, diagnosis and procedure information will pre-populate for you.
- To document the clinical criteria, click the [Document Clinical](#) button

Authorization Request



Patient : PAT-00014065 **Name :** Barth, Oliva **DOB :** 5/19/1947 **Gender :** Female

[show more](#)

Authorization : EPS-00014362 **Type :** Procedure Pre-authorization **Status :** NoDecisionYet

[show more](#)

Diagnosis Codes : C43.7(ICD-10 Diagnosis) *primary* **Procedure Codes :** 99233(CPT/HCPCS) *primary*

Procedure Code: 99233 (CPT/HCPCS)

[Document Clinical](#)

Requested Units: 1

Description : Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

[Submit Request](#)

[Cancel Request](#)

[Back](#)





MCG

- If there are clinical guidelines that apply to your request, they will be listed for you. Select [Add](#) to specify which clinical indications are present.

Procedure Code: 33422 (CPT/HCPCS)

Requested Units: 1

Description : Valvotomy, mitral valve\; open heart, with cardiopulmonary bypass

Guideline Title	Product	Code	Action
Cardiac Valve Replacement or Repair	ISC	S-290	add
No Guideline Applies			add

MCG

- If No Guideline Applies to your request, click [Add](#) under the Action column

Procedure Code: 99233 (CPT/HCPCS)

Requested Units: 1

Description : Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history\; A detailed examination\; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

Guideline Title	Product	Code	Action
No Guideline Applies			add

MCG

- You will be presented with a text box to document clinical information relevant to the review.
- Once all applicable data has been entered, click [Save](#).

No Guideline Applies

Please provide patient's clinical information...

1000 characters left for notes.

✓ Save

✕ Cancel



MCG

- When all clinical criteria has been entered, click [Submit Request](#) to finish this section and return to finalizing the review.

✓ **Procedure Code:** 99233 (CPT/HCPCS)

▼ show more

Requested Units: 1

Description : Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history\; A detailed examination\; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

✓ Submit Request

✕ Cancel Request


← Back



Attestation

- The last step in the submission process is to certify that all information is accurate and complete. Enter your username in the attestation section and click [Submit](#) to send the review to Telligen.

User Attestation

 I certify...

- that the submitted information is true, accurate and complete to the best of my knowledge.
- that the submitted information is supported within the patient's medical record.
- that I understand that any deliberate misrepresentation of any information in this medical review may subject me to liability under civil and criminal laws.
- that I understand an approval of a medical authorization request by Telligen does not guarantee payment for services.
- I agree to notify all involved parties of the outcome of this authorization request.

Acknowledging User *

Enter username

Submit

Comments

- After completing the attestation, users have the option to add a comment to the request if applicable.
- A comments modal will open, and the user can enter additional information related to the review.
- **This is not required to complete the review.**
- Click [Submit](#).

A screenshot of a 'Submit Review' modal window. The modal has a title bar with 'Submit Review' and a close button (X). Below the title bar, there is a section labeled 'Comments'. Inside this section is a large text input area with the placeholder text 'Comments'. At the bottom right of the modal, there are two buttons: a 'Cancel' button and a green 'Submit' button.

Questions?
