Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

August 2, 2022

Dear Behavioral Health Providers:

MDH thanks you for working with the Department as we transitioned to Optum as the State's Behavioral Health Administrative Services Organization (BHASO) and for continuing to serve Marylanders in need of behavioral health services. The unexpected pandemic that struck the Country resulted in unique challenges to maintaining up-to-date information in the Medicaid eligibility-verification system (EVS). EVS is used by the Public Behavioral Health System (PBHS) to determine eligibility, third-party liability (TPL) for coordination of benefits (COB), and long term care spans. Optum's intake of eligibility spans and issuance of denial reasons also faced challenges, leaving providers unaware of eligibility-related denials for 2020 services until as late as 2021.

Third Party Liability (TPL)

MDH has reviewed the impact of the above to behavioral health providers who submit claims through the BHASO. For dates of service July 1, 2019, through six months post the end of the Public Health Emergency (PHE), MDH has determined the following actions regarding TPL:

1) Where Optum had originally processed and paid a claim and later denied it for TPL, Optum will reprocess those claims to repay.
2) Where Optum has paid the claim and since found out that there is TPL, Optum will not reprocess the claim to deny for TPL.
3) For claims submitted after the TPL is in MMIS and in Incedo, claims will be denied for TPL if not submitted with the other coverage Explanation of Benefits (EOB).

MDH will revisit this process with Optum and providers once the end of the PHE is declared.

As Medicaid is the payer of last resort, it is in the provider's best interest to check EVS at least monthly – if not weekly or per visit – and to retain documentation for at least two years. The following chart outlines the actions providers need to take, depending on the information displayed in EVS and on the patient's attestation of no other insurance.

EVS Scenarios:

EVS Shows	Individual Indicates	Provider Action
other insurance	no other insurance	work with the individual to have EVS updated
no other insurance	has other insurance	submit the claim to the primary insurance prior to submitting the claim and EOB to Optum, and work with the individual to update EVS with the other insurance information
no other insurance	no other insurance	gain an attestation from the individual receiving services that they do not have other insurance, and obtain a copy of EVS

Optum will process claims based on TPL information in Incedo and claims submitted with EOBs. Therefore, providers have the option either to hold the claim until EVS is resolved or to submit the claim to the primary insurer on file, receive a denial, and then submit the EOB with denial to Optum.

Long Term Care (LTC)

A secondary issue has occurred relating to the coverage groups (T and L codes) used by the system to define Long Term Care spans, which were impacted by delays (pandemic, security incident) in updating the information. The result is that claims are being denied for participants as not being eligible for services, due to the LTC coverage group remaining on the participant file even when it should no longer apply.

MDH has instructed Optum to change their process so that it will assign full Medicaid benefits to participants with the T and L coverage codes. Optum will put in place supplemental processes for claims processors to review the true LTC-span admit and discharge date and to pay or deny claims as appropriate for that time span.

Once implemented, we caution providers that this could result in claims being paid during the true LTC span that should not be. Optum will retract these claims, and the provider will be responsible for returning the overpayment.

“No Eligibility”

Two denial categories, “Member's Coverage Not in Effect on Date of Service” and “Date of Service Not Covered/Authorized,” remain under review by Optum and MDH. As these reviews are completed, more information will be communicated to those providers who are impacted.

In summary, with these changes implemented, providers should experience a reduction in denials, while having clear guidance regarding Medicaid-eligibility verification and document retention. As the unwinding of the Public Health Emergency continues, and there is a return to “normal” Medicaid-determination processes, Medicaid will continue to monitor the impact on providers.

MDH appreciates the provider community and your continued participation as a provider under the PBHS.

Steven R. Schuh
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Maryland Department of Health