



STATE OF MARYLAND

DHMH

FOR OFFICE USE ONLY:

Patient Name:

MCO:

DOS:

Hospital:

Decision:

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

MCO/VO DISPUTE RESOLUTION COMMITTEE REVIEW FORM

Instructions:

The MCO/VO Dispute Resolution Committee reviews cases deemed complete. The submission is complete if the submission includes the following documents:

- (1) MCO Remittance Report evidencing the completion of the first level of appeal for the patient's MCO;
- (2) ValueOptions Remittance Report evidencing the completion of the first level of appeal for ValueOptions;
- (3) Patient's UB04 Form;
- (4) Patient's Medical Record from date(s) in question; and
- (5) MCO/VO Dispute Resolution Review Form filled out sections
 - a. Hospital Information;
 - b. Patient Claim Information;
 - c. ValueOptions Remittance information; and
 - d. MCO Remittance Information.

Send complete submissions to:

Maryland Department of Health and Mental Hygiene
ATTN: Maryland MCO/VO Dispute Resolution Committee
201 W Preston St
Room 523
Baltimore, MD 21201

Failure to include documents or properly fill out the form may result in either (1) significant delay in the Committee's review of the case or (2) return of the incomplete case file.

If the submission is complete, the Committee will return a decision within 45 days. Please refrain from contacting the Committee to check on the status of a decision within those 45 days.

Limitations:

The Committee's scope of authority to make determinations is limited to disputes concerning whether treatment is medical or psychiatric. Concerns regarding receipt of payment should not be sent to the Committee since ensuring payment is outside the scope of the Committee.

The Committee does not accept and will not review cases:

- (1) Where the date of service exceeds one year's time from the date stamp of envelope or email;
- (2) If the 3rd party payor is a commercial payor;
- (3) In the appeal process of either ValueOptions or the patient's MCO; or
- (4) Where the dispute concerns medical necessity or other procedural, or administrative, requirements necessary for payment.

The information required for a complete MCO/VO Dispute Resolution Form has PHI, therefore, submission should be faxed, mailed or sent via a password protected secure email

FOR OFFICE USE ONLY:

Patient Name: _____

MCO: _____

DOS: _____

Hospital: _____

Decision: _____

Hospital Information

Referring Contact: _____ Email: _____

Hospital Name: _____ Phone: _____

Mailing Address: _____

Patient Claim Information

Patient Name: _____ Patient DOB: _____

Patient MA#: _____ Patient MCO: _____

Patient SS#: (if no MA#) _____ Date(s) of Service: _____

Level of Service: _____ Primary Discharge Diagnosis: _____
(ex: ER, inpatient, etc) *(Attach UB04)*

ValueOptions Information

Date bill submitted to VO: _____ Remittance advice date: _____

Reason for denial: _____

Report date of appeal/decision: _____
(Attach all documentation)

Managed Care Organization Information

Date bill submitted to MCO: _____ Remittance advice date: _____

Reason for denial: _____

Report date of appeal/decision: _____
(Attach all documentation)

The information required for a complete MCO/VO Dispute Resolution Form has PHI, therefore, submission should be faxed, mailed or sent via a password protected secure email