2023
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

Maryland Medicaid

United Healthcare®
Community Plan

Welcome

Welcome to the UnitedHealthcare Community Plan care provider manual. This up-to-date reference PDF manual allows you and your staff to find important information such as how to process a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Find operational policy changes and other electronic transactions on our website at **UHCprovider.com**.

Click the following links to access different manuals:

- Administrative Guide: **UHCprovider.com/guides**. Under Administrative Guide for Commercial, Medicare Advantage and D-SNP, click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: **UHCprovider. com/guides**. Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Find Your Sta**.

Easily find information in this manual using the following steps:

1. Select CTRL+F
2. Type in the key word
3. Press Enter

If you have questions about the information or material in this manual, or about our policies, please call **Provider Services**.

Using this manual

If there is a conflict of information between your Agreement and manual, follow the manual unless your agreement states it is the source of truth for that topic. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

Terms and definitions as used in this manual:

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement
- "You," "your" or "care provider" refers to any health care professional subject to this manual, including physicians, clinicians, facilities and ancillary providers; except when indicated and all items are applicable to all types of health care providers subject to this manual
- "Community Plan" refers to UnitedHealthcare's Medicaid plan
- "Your Agreement," "Provider Agreement" or "Agreement" refers to your Participation Agreement with us
- "Us," "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this guide
- Any reference to "ID card" includes both a physical or digital card

Thank you for your participation in our program and the care you offer our members.

Table of Contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	1-877-842-3210
Training	**UHCprovider.com/training**	
Provider Portal	UHCprovider.com > Resources > **The UnitedHealthcare Provider Portal Resources** New user: UHCprovider.com > **New-user**	
CommunityCare Provider Portal Training	**CommunityCare Provider Portal User Guide**	
Provider Portal Support	email: **ProviderTechSupport@uhc.com**	1-855-819-5909
Resource Library	UHCprovider.com > Resources > **Resource Library**	

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Medicaid and HealthChoice

HealthChoice is the name of Maryland Medicaid's managed care program. There are approximately 1.7 million Marylanders enrolled in Medicaid and the Maryland Children's Health Program. With few exceptions, Medicaid beneficiaries under age 65 must enroll in HealthChoice. Individuals that do not select a Managed Care Organization (MCO) will be auto-assigned to an MCO with available capacity that accepts new enrollees in the county where the beneficiary lives. Individuals may apply for Medicaid, renew their eligibility and select their MCO online at **marylandhealthconnection.gov** or by calling **1-855-642-8572 (TYY: 711)**. Members are encouraged to select an MCO that their PCP participates with. If they do not have a PCP, they can choose one at the time of enrollment. MCO members who are initially auto-assigned can change MCOs within 90 days of enrollment. Members have the right to change MCOs once every 12 months. The HealthChoice Program's goal is to provide patient-focused, accessible, cost-effective, high-quality health care. The state assesses the quality of services provided by MCOs through various processes and data reports. To learn more about the state's quality initiatives and oversight of the HealthChoice Program, go to: **health.maryland.gov.** Care providers who wish to serve individuals enrolled in Medicaid MCOs are now required to register with Medicaid. UnitedHealthcare Community Plan also encourages care providers to actively participate in the Medicaid fee-for service (FFS) program. Beneficiaries will have periods of Medicaid eligibility when they are not active in an MCO. These periods occur after initial eligibility determinations and temporarily lapses in Medicaid coverage. While MCO care providers are not required to accept FFS Medicaid, it is important for continuity of care. For more information go to: **eprep.health.maryland.gov**. All care providers must verify Medicaid and MCO eligibility through the Eligibility Verification System (EVS) before rendering services. We do not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is their patient.

HealthChoice eligibility

All individuals qualifying for Maryland Medical Assistance or MCHP are enrolled in the HealthChoice Program, except for the following categories:

- Individuals who receive Medicare
- Individuals age 65 or older
- Newly eligible and 64½ or older

- Individuals who are eligible for Medicaid under spend down
- Medicaid participants who have been, or are expected to be, continuously institutionalized for more than:
  - 90 successive days in a long-term care facility, or
  - 30 successive days in an institution for mental disease (IMD)
- Individuals institutionalized in an intermediate care facility for persons with intellectual disabilities (ICFMR)
- Participants enrolled in the Model Waiver
- Participants who receive limited coverage, such as members who receive family planning; services through the Family Planning Waiver, or Employed Individuals with Disabilities Program
- Inmates of public institutions, including a state operated institution or facility
- A child receiving adoption subsidy who is covered under the parent's private insurance
- A child under state supervision receiving adoption subsidy who lives outside of the state, or
- A child who is in an out-of-state placement

All Medicaid participants who are eligible for the HealthChoice Program, without exception, will be enrolled in an MCO or in the Rare and Expensive Case Management Program (REM). The REM program is discussed in detail in Chapter 4.

Members must complete an updated eligibility application every year to maintain their coverage through the HealthChoice Program.

HealthChoice members are permitted to change MCOs if they have been in the same MCO for 12 months or more.

HealthChoice care providers are prohibited from steering members to a specific MCO. You are only allowed to provide information on which MCOs you participate with if a current or potential member seeks your advice about selecting an MCO.

Medicaid-eligible individuals who are not eligible for HealthChoice will continue to receive services in the Medicaid fee-for-service system.

How to join our network

For instructions on joining the UnitedHealthcare Community Plan provider network, go to **UHCprovider.com/join**. There you will find guidance on our credentialing process, how to sign up for self-service and other helpful information.

Already in network and need to make a change?

To change an address, phone number, add or remove physicians from your TIN, or other changes, go to My Practice Profile at UHCprovider.com > Our Network > **Demographics and Profiles.**

Introduction to UnitedHealthcare Community Plan: our approach to health care

Care Model

The Care Model program seeks to empower members, care providers and our community to improve care coordination and outcomes for individuals with complex medical conditions. Targeting UnitedHealthcare Community Plan members with chronic complex conditions who may overuse health care, the program helps address their needs holistically. Care Model examines medical, behavioral and social/environmental concerns to help members get the right care from the right care provider in the right place and at the right time.

The program provides interventions to members with complex medical, behavioral, social, pharmacy and specialty needs, resulting in better quality of life, improved access to health care and reduced expenses. Care Model provides a care management/coordination team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines.

This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan serves. Care Model provides:

- Member-specific care management encompassing medical, behavioral and social care
- An extended care team including pharmacist, medical and behavioral director, and community health workers
- Options that and facility-based visits to engage members, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plans
- Assistance with appointments with primary care providers (PCPs) and coordinating appointments. The clinical health advocate refers members to an RN, behavioral health advocate or other specialists as required for complex needs.
- Education and support with complex conditions
- Tools for helping members engage with care providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with challenging members

The Care Model program goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured by lower inpatient (IP) admission and ER rates
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames
- Identify and discuss behavioral health needs
- Improve access to pharmacy
- Identify and remove social and environmental barriers to care
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS®) and Maryland Department of Health metrics
- Empower the member to manage their complex/chronic illness or problem and care transitions
- Improve coordination of care through dedicated staff resources and to meet unique needs
- Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services

To refer your patient who is a

UnitedHealthcare Community Plan member to Care Model, call the special needs coordinator at **1-800-460-5689**. You may also call Provider Services at **1-877-842-3210**.

Overview of UnitedHealthcare Community Plan provider services

UnitedHealthcare Community Plan manages a comprehensive care provider network of independent practitioners and facilities. The network includes health care professionals such as PCPs, specialists, medical facilities, allied health professionals and ancillary service care providers. UnitedHealthcare Community Plan offers several options to support care providers who need assistance.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster. Learn the differences by viewing our Digital Solutions Comparison Guide at UHCprovider.com > Resources > the UnitedHealthcare Provider Portal Resources > **Digital Solutions Comparison Guide**. Care providers in the UnitedHealthcare network will conduct business with us electronically. This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents, including appeals requests and decisions and prior authorization requests and decisions. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use Application Programming Interface (API), Electronic Data Exchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

API

API is becoming the newest digital method in health care to distribute information to care providers and business partners in a timely and effective manner.

API is a common programming interface that interacts

between multiple applications. Our API solutions allow you to electronically receive detailed data on claims status and payment, eligibility and benefits, claim reconsiderations and appeals (with attachments), prior authorization, referrals and documents. Information returned in batch emulates data in the UnitedHealthcare Provider Portal and complements EDI transactions, providing a comprehensive suite of services. It requires technical coordination with your IT department, vendor or clearinghouse. The data is in real time and can be programmed to be pulled repetitively and transferred to your practice management system or any application you prefer. For more information, visit **UHCprovider.com/api**.

EDI

EDI is an online resource using your internal practice management or hospital information system to exchange transactions with us through a clearinghouse.

The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging into different payer websites to manually request information. This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions.

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses
- EDI transactions available to care providers are:
  - Claims (837),
  - Eligibility and benefits (270/271)
  - Claims status (276/277)
  - Referrals and authorizations (278)
  - Hospital admission notifications (278N)
  - Electronic remittance advice (ERA/835)

Visit **UHCprovider.com/EDI** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/en/resource-library/edi/edi-optimization.html**.

Getting started
- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system
- Contact clearinghouses to review which electronic transactions can interact with your software system

Read our **Clearinghouse Options** page for more information.
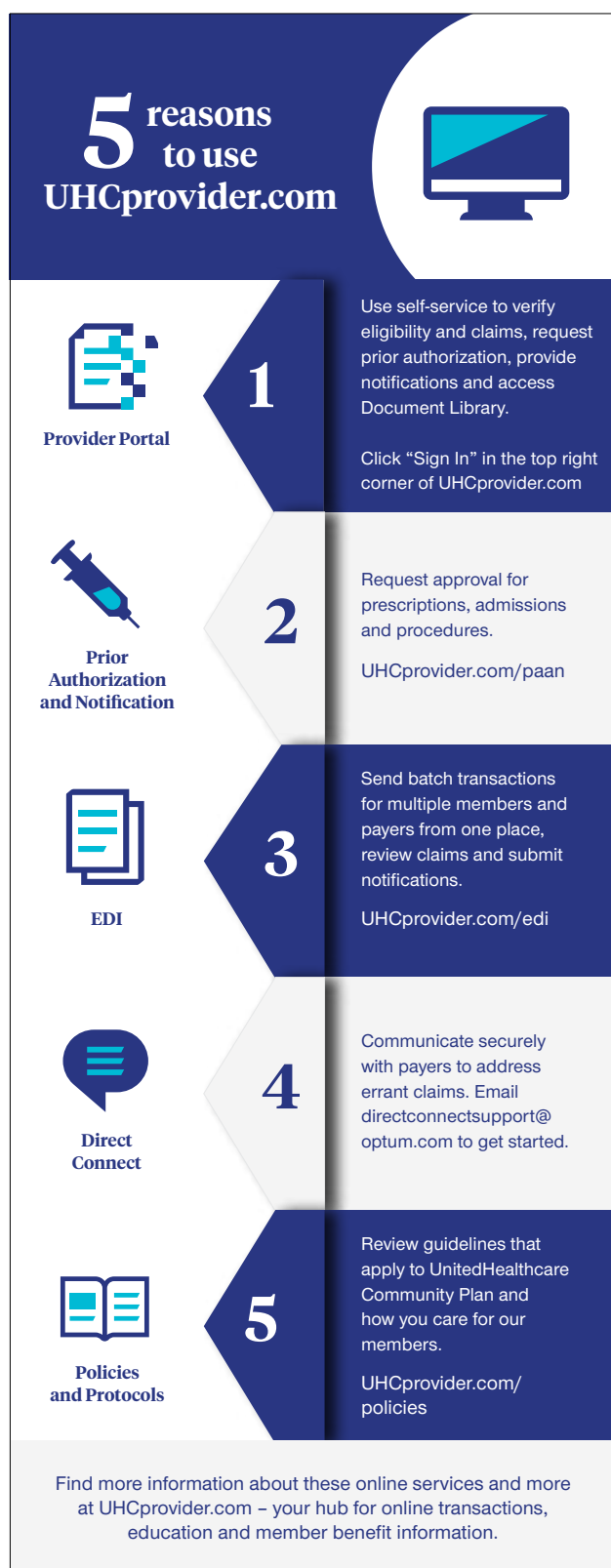
Point of Care Assist™

When made available by UnitedHealthcare Community Plan, you will do business with us electronically. Point of Care Assist integrates members' UnitedHealthcare health data within the Electronic Medical Record (EMR) to provide real-time insights of their care needs, aligned to their specific member benefits and costs. This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to **UHCprovider.com/poca**.

UHCprovider.com

This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.

UnitedHealthcare Provider Portal

This secure portal is accessible from UHCprovider.com. It allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks such submitting prior authorization requests, checking claim status, submitting appeal requests, and find copies of PRAs and letters in Document Library. All at no cost to you and without needing to pick up the phone.

5 reasons to use UHCprovider.com

1 Provider Portal
Use self-service to verify eligibility and claims, request prior authorization, provide notifications and access Document Library.

Click "Sign In" in the top right corner of UHCprovider.com

2 Prior Authorization and Notification
Request approval for prescriptions, admissions and procedures.

UHCprovider.com/paan

3 EDI
Send batch transactions for multiple members and payers from one place, review claims and submit notifications.

UHCprovider.com/edi

4 Direct Connect
Communicate securely with payers to address errant claims. Email directconnectsupport@optum.com to get started.

5 Policies and Protocols
Review guidelines that apply to UnitedHealthcare Community Plan and how you care for our members.

UHCprovider.com/policies

Find more information about these online services and more at UHCprovider.com – your hub for online transactions, education and member benefit information.

To access the portal, go to **UHCprovider.com/en/access.html** to create or sign in using a One Healthcare ID. To use the portal: If you already have a One Healthcare ID (formerly known as Optum ID), simply go to **UHCprovider.com** and click Sign In in the upper right corner to access the portal. If you need to set up an account on the portal, follow these steps to register.

The following are the most frequently used self-service transactions on the Provider Portal:

- **Eligibility and Benefits** — View patient eligibility and benefits information for most plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims** — Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **Prior Authorization and Notification** — Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/paan**.
- **Specialty Pharmacy Transactions** — Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile** — View and update your care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **Document Library** — Access reports and claim letters for viewing, printing or downloading. The Document Library Roster provides member contact information in a PDF and can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.

Go to **UHCprovider.com/portal** to learn more about the portal. You can access self-paced user guides for many of the tools and tasks available in the portal at UHCprovider.com/training > **Digital Solutions**.

Direct Connect

Direct Connect is a free online portal that lets you securely communicate with payers to address errant claims. This portal can replace previous methods of letters, faxes, phone calls and spreadsheets. It also helps:

- Manage overpayments in a controlled process
- Create a transparent view between care provider and payer
- Avoid duplicate recoupment and returned checks
- Decrease resolution time frames
- Run real-time reporting to track statuses of inventories in resolution process
- Provide control over financial resolution methods

All users will access Direct Connect using the Provider Portal. On-site and online training is available.

Email **directconnectsupport@optum.com** to get started with Direct Connect.

Provider inquiries

Provider Services is the primary contact for care providers who require assistance. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan.

Provider Services can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

Provider Services works closely with all departments in UnitedHealthcare Community Plan.

Compliance

Health Insurance Portability and Accountability Act (HIPAA) mandates National Provider Identifier (NPI) usage in all standard transactions (claims, eligibility, remittance advice, claims status request/response, and authorization request/response) for all health care providers who handle business electronically.

Cultural competency

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs, and activities receiving federal financial assistance, such as Medicaid. Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental, or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. UnitedHealthcare Community Plan expects you to treat all members with dignity and respect as required by federal law including honoring member's beliefs, be sensitive to cultural diversity, and foster respect for member's cultural backgrounds. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs, and activities receiving federal financial assistance, such as Medicaid.

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect access to health care participation. You must help UnitedHealthcare Community Plan meet this obligation for our members. For Cultural Competency training visit UHCprovider.com > Resources > Resource Library > Patient Health and Safety > **Cultural Competency**.

UnitedHealthcare Community Plan offers the following support services:

- **Language Interpretation Line:** We provide oral interpreter services 24 hours a day, 7 days a week to our members free of charge. More than 240 nonEnglish languages and hearing impaired services are available. If a UnitedHealthcare Community Plan member needs Interpreter Services, they can call the phone number on their ID card. If you need a professional interpreter, members may call Member Services at **1-800-318-8821, TTY 711**, 8 a.m.-7 p.m., Monday through

Friday.

- **Materials for limited English-speaking members:** We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members. For more information, go to **uhc.com/legal/ nondiscrimination-and-language-assistance- notices**.

Health literacy — LEP or reading skills

UnitedHealthcare Community Plan is required to verify that Limited English Proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays, denials of services, receive care, services based on inaccurate or incomplete information. You must deliver services in a culturally effective manner to all members, including those with LEP or reading skills.

Access for individuals with disabilities

Title III of the Americans with Disabilities Act (ADA) mandates that public accommodations, such as a physician's office, be accessible and flexible to those with disabilities. Under the provisions of the ADA, no qualified individual with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity; or be subjected to discrimination by any such entity. Care provider offices must be accessible to persons with disabilities. Care providers must also make efforts to provide appropriate accommodations such as large-print materials and easily accessible doorways.

Privileges

To help our members access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable in-network facilities or arrangements with an in-network care provider to admit and provide facility services. This includes full admitting hospital privileges, ambulatory surgery center privileges and/or dialysis center privileges.

How to contact us

We no longer use fax numbers for most departments, including benefits, prior authorization and claims.

Topic	Contact	Information
Benefits	**UHCprovider.com/benefits** 1-877-842-3210	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit **UHCprovider.com/cardiology** 1-877-842-3210	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Care Model (Care Management/ Disease Management)	Special Needs Coordinator 1-800-460-5689	Refer high-risk members or any member in need of care coordination services (e.g., asthma, diabetes, obesity).
Chiropractor Care/ Occupational Therapy/Physical Therapy/Speech Language Pathology	**myoptumhealthphysicalhealth.com** 1-800-873-4575	Chiropractic services are limited to members ages 20 and younger. Occupational therapy, speech language pathology, and physical therapy services for members 20 years of age and younger must be billed Fee-for-Service (FFS) directly to the Medicaid program.
Claims	Use the Provider Portal at **UHCprovider.com/claims** 1-877-842-3210 Submit electronically (preferred method) • Through a third-party vendor, e.g., WebMD (payer ID 87726) • Directly to UnitedHealthcare Community Plan at **UHCprovider.com/claims** Paper using a CMS 1500 or UB-04 (CMS 1450) (See Attachment #6 and #7) • Mailing address: **UnitedHealthcare Community Plan** P.O. Box 31365 Salt Lake City, UT 84131	Verify a claim status or get information about proper completion or submission of claims. For claims that process on the CSP Facets system, use 1 rendering provider per claim. Claims with multiple rendering providers will have to be formatted as separate claims (using only the 2310B loop) or DO NOT USE 2420A.

Topic	Contact	Information
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access the Provider Portal 1-877-842-3210 Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Electronic Data Intake Claim Issues	**EDI Issue Reporting Form** **ac_edi_ops@uhc.com** 1-800-210-8315	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues	**UHCprovider.com/edi** 1-800-842-1109	Contact Optum with EDI-related questions m,gncfbdxvz bnm,.olp;[']AQ.
electronic Provider Revalidation and Enrollment Portal (ePREP)	**54w**	Register and maintain demographic information using the ePREP portal. *Maryland State Requirement
Eligibility	To access eligibility information, go to **UHCprovider.com,** then Sign In to the Provider Portal or go to **UHCprovider.com/eligibility**. Eligibility Verification System (EVS) 1-866-710-1447 Provider Services 1-877-842-3210	Confirm member eligibility.
Enterprise Voice Portal	1-877-842-3210	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.

Topic	Contact	Information
Fraud and Abuse (Payment Integrity)	Maryland Office of Legislative Audits > Fraud Hotline > List of Hotlines > **Medicaid Benefits** Maryland Office of the Inspector General Fraud Hotline: 1-866-770-7175 Submit written report to: **Maryland Department of Health** **Office of the Inspector General** **Program Integrity Division** 201 W. Preston Street Baltimore, MD 21201 **MDH.OIG@Maryland.gov** 1-410-767-5784 Office 1-410-333-7194 Fax Payment Integrity Information: website: UHCprovider.com/MDcommunityplan > **Integrity of Claims, Reports, and Representations to the Government** Reporting: **uhc.com/fraud** 1-800-455-4521 or 1-877-401-9430	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Medicaid	**mmcp.health.maryland.gov** Maryland Department of Health: 1-410-767-6500 or 1-877-463-3464 201 W. Preston Street Baltimore, MD 21201-2399	Contact Maryland Department of Health directly.

Topic	Contact	Information
Medical Claim Disputes	Sign in to the Provider Portal at **UHCprovider.com** or go to **UHCprovider.com/claims** 1-877-842-3210 Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 Appeals mailing address: **UnitedHealthcare Community Plan Appeals and Claims Disputes** P.O. Box 31365 Salt Lake City, UT 84131	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com** 1-800-318-8821 (TTY 711)	Assist members with issues or concerns. Available 8 a.m.–7 p.m. Eastern Time, Monday through Friday.
Mental Health & Substance Abuse (Optum Maryland)	1-800-888-1965 1-866-835-2755 (TTY)	Refer members for behavioral health services Monday through Friday, from 8 a.m.-6 p.m. Eastern Time, excluding major holidays. (A PCP referral is not required.)
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	Member Services: 1-800-318-8821 (TTY 711)	Available 8 a.m.–7 p.m. Eastern Time, Monday through Friday.
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov** 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Resource Team (NMRT)	**networkhelp@uhc.com** 1-877-842-3210	Self-service functionality to update or check credentialing information.
NurseLine	1-877-440-0251	Available 24 hours a day, 7 days a week.

Topic	Contact	Information
Obstetrics, Pregnancy and Baby Care	Healthy First Steps **uhchealthyfirststeps.com** 1-800-599-5985	For pregnant members, contact Healthy First Steps by calling or filling out the Pregnancy Notification Form.
One Healthcare Support Center	**ProviderTechSupport@uhc.com** PreCheck My Script App: 1-888-355-8996	Available 8 a.m.–10 p.m. Eastern Time, Monday through Friday; 7 a.m.–7 p.m. Eastern Time, Saturday; and 10 a.m.–7 p.m. Eastern Time, Sunday.
Pharmacy Services	UHCprovider.com/MDcommunityplan > **Pharmacy Resources and Physician-Administered Drugs** Health Care Professionals Contact Form at **professionals.optumrx.com**	OptumRx oversees and manages our network pharmacies. Use the Provider Portal to access the PreCheck MyScript tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.
Prior Authorization/ Notification for Pharmacy	UHCprovider.com > Prior Authorization > **PreCheck MyScript App**	Request authorization for medications as required.
Prior Authorization/ Advance Notification/ Admission Notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online Tool: **UHCprovider.com/paan** Phone: Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications." Or call 1-877-842-3210.	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required • Complete the notification or prior authorization process • Upload medical notes or attachments • Check request status Information and advance notification/prior authorization lists: Visit UHCprovider.com/MDcommunityplan > **Prior Authorization and Notification**.
Provider Services	1-877-842-3210	Available 8 a.m.–6 p.m. Eastern Time, Monday through Friday.
Radiology Prior Authorization	**UHCprovider.com/radiology** EviCore 1-866-889-8054	Prior authorization or a current list of CPT codes that require prior authorization.

Topic	Contact	Information
Referrals	UHCprovider.com > **Referrals** or use Referrals on the Provider Portal. Click Sign in at the top right corner of UHCprovider.com, then click Referrals.	Submit new referral requests and check the status of referral submissions.
Reimbursement Policy	UHCprovider.com/MDcommunityplan > **Policies and Clinical Guidelines**	View reimbursement policies that apply to UnitedHealthcare Community Plan members. Regularly visit this site to view reimbursement policy updates.
Technical Issues	website: **UHCprovider.com/en/contact-us/ technical-assistance.html** email: **ProviderTechSupport@uhc. com** 1-866-209-9320 for Optum support or 1-866-842-3278, Option 1 for web support	Call if you have issues logging in to the Provider Portal, you cannot submit a form, etc.
Tobacco Free Quit Line	1-800-784-8669	Refer members to services for quitting tobacco/ smoking.
UnitedHealthcare Web Support	1-866-842-3278, Option 1	Available Monday through Friday, 8 a.m. to 10 p.m. Eastern Time to answer questions about **UHCprovider.com**, your One Healthcare ID registration, and login or Provider Portal applications. Representatives cannot provide assistance with the results of Provider Portal apps (e.g., claim denials).
Website for Maryland Community Plan	**UHCprovider.com/MDcommunityplan**	Access your state-specific Community Plan information.

Chapter 2: Care Provider Standards and Policies

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	
Enterprise Voice Portal		
Eligibility	**UHCprovider.com/eligibility**	1-877-842-3210
Referrals	UHCprovider.com > **Referrals**	
Provider Directory	UHCprovider.com > Our Network > **Find a Provider**	

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Overview of care provider responsibilities

Nondiscrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on age, sex, race, physical or mental handicap, national origin, religion, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members as patients or with UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

UnitedHealthcare Community Plan members and/or their representative(s) may take part in the planning and implementation of their care. To help ensure members and/or their representative(s) have this chance,

UnitedHealthcare Community Plan requires you:
1. Educate members, and/or their representative(s) about their health needs
2. Share findings of history and physical exams
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.
4. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options
5. Collaborate with the plan care manager in developing a specific care plan for members enrolled in high-risk care management

Provide official notice

Write to us within 10 calendar days if any of the following events happen:
1. Bankruptcy or insolvency
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program
4. Loss or suspension of your license to practice
5. Departure from your practice for any reason
6. Closure of practice

Update demographic information

You may use the Care Provider Demographic Information Update Form for demographic changes or to update NPI information for care providers in your office. This form is located at UHCprovider.com > Our Network > Demographics and Profiles > My Practice Profile > **Care Provider Paper Demographic Information Update Form**.

PCP contract terminations

If you are a PCP, and we terminate your contract for any of the following reasons, the member assigned to you may elect to change to another MCO in which you participate by calling the Enrollment Broker within 90 days of the contract termination:

- For reasons other than the quality of care or your failure to comply with contractual requirements related to quality assurance activities or
- UnitedHealthcare Community Plan reduces your reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to UnitedHealthcare Community Plan by the Department, and UnitedHealthcare Community Plan and you are unable to negotiate a mutually acceptable rate

Arrange substitute coverage

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers and care professionals.

For the most current list of network professionals, review our Provider Directory at UHCprovider.com > Our Network > **Find a Provider**.

Administrative terminations for inactivity

Up-to-date directories are a critical part of providing our members with the information they need to take care of their health. To accurately list care providers who treat UnitedHealthcare Community Plan members, we:

1. End Agreements with care providers who have not submitted claims for UnitedHealthcare Community Plan members for 1 year and have voluntarily stopped participation in our network
2. Inactivate any tax identification numbers (TINs) with no claims submitted for 1 year. This is not a termination of the provider Agreement. Call UnitedHealthcare Community Plan to reactivate a TIN.

Changing an existing TIN or adding a health care provider

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form.

- Download the W-9 form at irs.gov > Forms & Instructions > **Form W-9**
- Download the Care Provider Demographic Information Update Form at UHCprovider.com > Our Network > Demographics and Profiles > My Practice Profile > **Care Provider Paper Demographic Information Update Form**
- To update your care provider information online, go to UHCprovider.com > Our Network > Demographics and Profiles > **My Practice Profile**

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Send this information to the email listed on the bottom of the demographic change request form.

Updating your practice or facility information

You can update your practice information through the Provider Data Management application on **UHCprovider.com**. Go to UHCprovider.com > Our Network > Demographics and Profiles > My Practice Profile > **Care Provider Paper Demographic Information Update Form**. Or submit your change by:

- Completing the **Care Provider Demographic Change Form** and emailing it to the appropriate address listed on the bottom of the form
- Calling our Enterprise Voice Portal at **1-877-842-3210**.

After-hours care

Life-threatening situations require the immediate services of an emergency department. Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu.

If a member contacts you after hours, they must be able to speak with a care provider who can review the members' symptoms and determine the right place for care.

Participate in quality initiatives

You must help our quality assessment and improvement activities. You must also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for diseases and conditions. This is determined by United States government agencies and professional specialty societies. See Chapter 10 for more details on the initiatives.

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 10 years or longer if required by applicable statutes or regulations.

Performance data

You must allow the plan to use care provider performance data.

Comply with protocols

You must comply with UnitedHealthcare Community Plan's and Payer's Protocols, including those contained in this manual.

You may view protocols at **UHCprovider. com**.

Office hours

You must provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

Follow medical record standards

Please reference **Chapter 9** for Medical Record Standards.

Advance directives

You are required to comply with federal and state law regarding advance directives for adult members. Maryland advance directives include Living Will, Health Care Power Of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of health care when the individual is incapacitated. The advance directive must be prominently displayed in the adult member's medical record.

Requirements include:

- Providing written information to adult members regarding each individual's rights under Maryland law to make decisions regarding medical care and any care provider-written policies concerning advance directives (including any conscientious objections)
- Documenting in the member's medical record, whether the adult member has been provided the information and whether an advance directive has been executed
- Not discriminating against a member because of their decision to execute or not execute, an advance directive and not making it a condition for the provision of care
- Educating staff on issues related to advance directives, as well as communicating the member's wishes to attending staff at hospitals or other facilities
- Educate patients on Advance Directives (durable power of attorney and living wills)
- Encourage patients to utilize electronic advance care planning documents
- MCOs are required to make the Advance Directives Information Sheet available during enrollment and in member publications, on their website, and at the member's request

Find advance directive forms and frequently asked questions at **marylandattorneygeneral.gov/Pages/HealthPolicy/advancedirectives.aspx**.

Communications toolkit for the Advance Directive Information Sheet can be found at: **mhcc.maryland.gov.**

Agreement, member and care provider concerns

If you have a concern about your Agreement with

us, send a letter with the details to the address in your contract. A representative will look into your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if any party remains dissatisfied, you may file for arbitration.

If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the Member Handbook at **UHCCommunityPlan.com**.

Also reference Chapter 12 of this manual for information on Provider Claim Disputes, Appeals and Grievances.

Appointment standards (MDH Access and Availability Standards)

PCPs must be available to members by phone 24 hours a day, 7 days a week. Or they must have arrangements for phone coverage by another designated participating medical care provider. Care provider offices must have a phone message or answering service available to members after office hours that instructs them how to contact the care provider for urgent or emergency conditions.

An office telephone that rings continuously without answer is an unacceptable after-hours response.

PCPs must comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week. Offices must have a phone message or answering service that instructs members how to

contact a care provider or urgent or emergency conditions.

- Emergency care: Immediately
- Urgent care: within 48 hours of request
- Adult routine preventative care: within 30 days of request
- Well-child assessment/preventive care/EPSDT: within 30 days of request

Waiting period: The in-office waiting period for regular appointments should not exceed 1 hour of the scheduled appointment time.

After-hours care phone number: Provide medically necessary emergency phone service 24 hours a day, 7 days a week. Offices must have a phone message or answering service available that instructs members how to contact a care provider for urgent or emergency conditions.

Specialty care

Specialists should arrange appointments for new and existing patients within 30 days.

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- Initial health visits: pregnant and postpartum members must be seen within 10 days of request
- First and second trimester: within 7 calendar days of request
- Third trimester: within 3 days of request
- High-risk: within 3 calendar days of identification of high risk

UnitedHealthcare Community Plan periodically conducts surveys to check appointment availability and access standards. All care providers must participate in all activities related to these surveys.

Provider Directory

The medical and mental health care provider directory is located at UHCprovider.com > Our Network > **Find a Provider**.

You are required to tell us, within 5 business days, if there are any changes to your ability to accept new patients. If a member, or potential member, contacts you, and you are no longer accepting new patients, report any inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional assistance in finding a care provider.

We are required to audit a sample of providers quarterly. We require you to confirm your information is accurate or provide us with applicable changes.

If we do not receive a response from you within 30 business days, we have an additional 15 business days to contact you. If these attempts are unsuccessful, we notify you that if you continue to be nonresponsive we will remove you from our care provider directory after 10 business days.

If we receive notification the directory information is inaccurate, you may be subject to corrective action.

In addition to outreach for annual or bi-annual attestations, we are required to make outreach if we receive a report of incorrect provider information. We are required to confirm your information.

To help ensure we have your most current provider directory information, submit applicable changes using My Practice Profile. To access the application, visit UHCprovider.com > Our Network > **Demographics and Profiles** > Go to Practice/Facility Profile App on the Provider Portal.

Provider attestation

Confirm your provider data every quarter through the Provider Portal on **UHCprovider.com** or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access the My Practice Profile App to make many of the updates required in this section.

Prior authorization request

Prior authorization requests may include procedures, services, and/or medication.

Coverage may only be provided if the service or medication is deemed medically necessary, or meets specific requirements provided in the benefit plan.

You should take the following steps before providing medical services and/or medication to UnitedHealthcare

Community Plan members:

- Verify eligibility using the Provider Portal at **UHCprovider.com/eligibility** or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization from the Provider Portal:
  1. To access the Prior Authorization app, go to **UHCprovider.com**, then Sign In
  2. Select the **Prior Authorization and Notification app**
  3. View notification requirements

You may also find information on **UHCprovider.com/MDcommunityplan** > Prior Authorization Requirements.

Identify and bill other insurance carriers when appropriate.

If you have questions, please call UnitedHealthcare Web Support at **1-866-842-3278**, option 1, 8 a.m.–10 p.m. Eastern Time, Monday through Friday.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

- Urgent: 24 hours
- Nonurgent: 10 business days

PCP requirements

PCPs are an important partner in the delivery of care, and members may seek services from any participating care provider. The HealthChoice program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

The PCP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in 4 critical areas: access,

coordination, continuity and prevention. As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24 hours a day, 7 days a week coverage and backup coverage when they are not available.

Medical doctors (M.D.s), doctors of osteopathy (DOs), nurse practitioners (NPs) and physician assistants (PAs) from any of the following practice areas can be PCPs:

- General practice
- Internal medicine
- Family practice
- Pediatrics

NPs and PAs may enroll with the state as solo providers.

Members may change their assigned PCP by contacting **Member Services** at any time during the month. Customer service is available 8 a.m.–7 p.m., Monday through Friday.

We ask members who don't select a PCP during enrollment to select one. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

Members have direct access (without a referral or authorization) to any OB/GYNs, midwives, PAs, or NPs for family planning services and pregnancy services when begun before enrollment with UnitedHealthcare Community Plan.

Consult with other appropriate health care professionals to develop individualized treatment plans for UnitedHealthcare Community Plan members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing
- Submit all accurately coded claims or encounters timely
- Provide all well baby/well-child services
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a 1-MD practice and at least 30 hours per week for a 2- or more MD practice

- Be available to members by telephone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

Primary care providers (PCPs)

The PCP serves as the entry point for access to health care services. The PCP is responsible for providing members with medically necessary covered services, or for referring a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member. Members can choose a physician or NP as their PCP. The PCP will act as a coordinator of care and has the responsibility to provide accessible, comprehensive, and coordinated health care services covering the full range of benefits.

The PCP is required to:

- Address the member's general health needs
- Treat illnesses
- Coordinate the member's health care
- Promote disease prevention and maintenance of health
- Maintain the member's health records
- Refer for specialty care when necessary

If a member's PCP is not a women's health specialist, UnitedHealthcare Community Plan of Maryland let her see a women's health specialist within the UnitedHealthcare Community Plan network without a referral for covered services necessary to provide women's routine and preventive health care services. Prior authorization is required for certain services.

Responsibilities of PCPs

In addition to meeting the requirements for all care providers, PCPs must:

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment

- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to Provider Services or our clinical or pharmacy departments as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards
- Comply with the MDH Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

RHC, FQHC or PCC

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a rural health clinic (RHC), federally qualified health center (FQHC) or primary care clinic (PCC) as their PCP.

- **RHC –** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.
- **FQHC –** An FQHC is a center or clinic that provides

primary care and other services. These services include:

- Preventive (wellness) health services from a care provider, PA, NP and/or social worker
- Mental health services
- Immunizations (shots)
- Home nurse visits

- **PCC –** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a primary care clinic that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

PCP checklist

✓ Verify eligibility and benefits on UHCprovider.com. Click "Sign In" in the top right corner to access the Provider Portal, or call Provider Services.

✓ Check the member's ID card at the time of service. Verify member with photo identification.

✓ Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/paan.

✓ Refer patients to UnitedHealthcare Community Plan participating specialists when needed.

✓ Identify and bill other insurance carriers when appropriate.

✓ Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form.

Specialty care providers

Specialists are responsible for providing services in accordance with the accepted community standards of care and practices. MDH requires UnitedHealthcare Community Plan to maintain a complete network of adult and pediatric care providers adequate to deliver the full scope of benefits. If a PCP cannot locate an appropriate specialty care provider, call **UnitedHealthcare Community Plan** Member Services at **1-800-318-8821 (TTY 711)**, Monday-Friday, 8 a.m. to 7 p.m., for assistance.
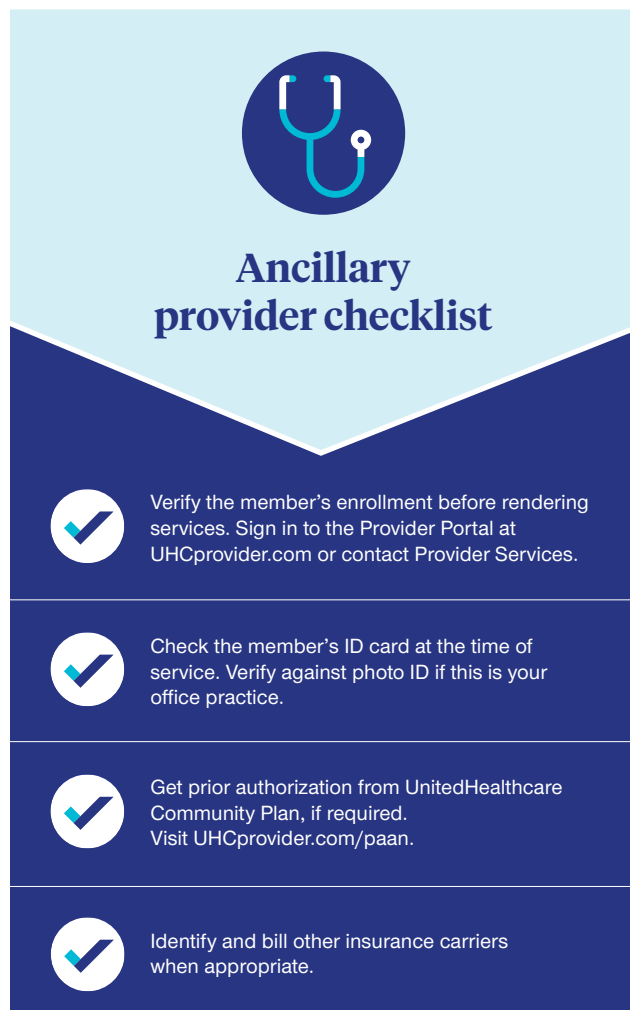
Specialist responsibilities

In addition to applicable requirements for all care providers, specialists must:

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer
- Verify the eligibility of the member before providing covered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the MDH Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 7 days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

Specialists may use medical residents in all specialty

care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for after-hours access. PCPs and specialists must take part in all survey-related activities.

Ancillary provider checklist

✓ Verify the member's enrollment before rendering services. Sign in to the Provider Portal at UHCprovider.com or contact Provider Services.

✓ Check the member's ID card at the time of service. Verify against photo ID if this is your office practice.

✓ Get prior authorization from UnitedHealthcare Community Plan, if required.
Visit UHCprovider.com/paan.

✓ Identify and bill other insurance carriers when appropriate.

Ancillary provider responsibilities

Ancillary providers include:
- Freestanding radiology
- Freestanding clinical labs
- Home health
- Hospice
- Dialysis
- Durable medical equipment

- Infusion care
- Therapy
- Ambulatory surgery centers
- Freestanding sleep centers
- Other noncare providers

PCPs and specialists must use the UnitedHealthcare Community Plan ancillary network.

UnitedHealthcare Community Plan participating ancillary providers should maintain sufficient facilities, equipment, and personnel to provide timely access to medically necessary covered services.

Reporting communicable disease

You must ensure that all cases of reportable communicable disease that are detected or suspected in a member by either a clinician or a laboratory are reported to the LHD as required by Health - General Article, §§18-201 to 18-216, Annotated Code of Maryland and COMAR 10.06.01 Communicable Diseases. Any health care provider with reason to suspect that a member has a reportable communicable disease or condition that endangers public health, or that an outbreak of a reportable communicable disease or public health-endangering condition has occurred, must submit a report to the health officer for the jurisdiction where the care provider cares for the member.

- The care provider report must identify the disease or suspected disease and demographics on the member including the name age, race, sex and address of residence, hospitalization, date of death, etc. on a form provided by the Department (DHMH-1140) as directed by COMAR 10.06.01
- With respect to patients with tuberculosis, you must:
  - Report each confirmed or suspected case of tuberculosis to the local health department (LHD) within 48 hours
  - Provide treatment in accordance with the goals, priorities, and procedures set forth in the most recent edition of the Guidelines for Prevention and Treatment of Tuberculosis, published by MDH

Chapter 3: Care Provider Office Procedures and Member Benefits

Key contacts

Topic	Link	Phone Number
Member Benefits	**UHCCommunityPlan.com/MD**	1-800-318-8821
Member Handbook	**UHCCommunityPlan.com/MD.** Go to Plan Details, then Member Resources, View Available Resources	
Provider Services	**UHCprovider.com**	1-877-842-3210
Prior Authorization	**UHCprovider.com/paan**	
D-SNP	UHCprovider.com/MD > Medicare > **Dual Complete Special Needs Plans**	

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

MCO benefits and services overview

UnitedHealthcare Community Plan must provide comprehensive benefits equivalent to the benefits that are available to Maryland Medicaid participants through the Medicaid fee-for-service system. Only benefits and services that are medically necessary are covered.

Go to **UHCCommunityPlan.com/MD** or UHCprovider.com > **Eligibility** for more information.

Audiology services

Audiology services will be covered by **UnitedHealthcare Community Plan** for both adults and children. For individuals under age 21, bilateral hearing amplification devices are covered by the MCO. For adults 21 and older, unilateral hearing amplification devices are covered by the MCO. Bilateral hearing amplification devices are only covered for adults before age 21.

Blood and blood products

We cover blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin and albumin.

Case management services

We cover case management services for members who need such services including, but not limited to, members of state-designated special needs populations as described in Section II. If warranted, a case manager will be assigned to a member when the results of the initial health screen are received by the MCO or when the state requests them. A case manager may conduct home visits as necessary as part of UnitedHealthcare Community Plan case management program.

Review the **Care Model** section for more information on our case management program.

Clinical trial items and services

We cover certain routine costs that would otherwise be a cost to the member.

Dental services

The Maryland Healthy Smiles Dental Program (MHSDP) provides comprehensive dental services. These include:
- Diagnostic
- Preventative
- Restorative
- Endodontic
- Periodontic
- Certain prosthodontic services
- Oral maxillofacial surgery
- Sedation

Diabetes care services

We cover all medically necessary diabetes care services. For members who have been diagnosed with diabetes, we cover:
- Diabetes nutrition counseling
- Diabetes outpatient education
- Diabetes-related durable medical equipment (DME) and disposable medical supplies, including:
  - Blood glucose meters for home use
  - Finger sticking devices for blood sampling
  - Blood glucose monitoring supplies
  - Diagnostic reagent strips and tablets used for testing for ketone and glucose in urine and glucose in blood
- Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear.

Diabetes prevention program

Members are eligible to participate in an evidence-based diabetes prevention program established by the Centers for Disease Control and Prevention if they:
- Are 18 to 64 years old
- Are overweight or obese
- Have an elevated blood glucose level or a history of gestational diabetes mellitus
- Have never been diagnosed with diabetes
- Are not currently pregnant

Diagnostic and laboratory services

Diagnostic services and laboratory services performed by care providers who are CLIA certified or have a waiver of a certificate registration and a CLIA ID number are covered. However, viral load testing, genotypic, phenotypic or HIV/AIDS drug resistance testing used in treatment of HIV/AIDS are reimbursed by the state.

Dialysis services

We cover dialysis services either through participating care providers or members can self-refer to non-participating Medicare certified care providers. HealthChoice members with End Stage Renal Disease (ESRD) are eligible for the REM Program.

Disease management

We offer disease management for members with the following chronic conditions:

UnitedHealthcare Community Plan has developed disease management (DM) strategies to maximize success for our members with chronic conditions such as diabetes and asthma. Members in DM programs receive ongoing disease-specific education and self-management tools.

Eligible members of UnitedHealthcare Community Plan do not have to enroll. They are screened and admitted when we identify them as living with a disease. UnitedHealthcare Community Plan informs you of the member's participation. We will work with you and our members to identify and prevent complications, promote optimal health, and help ensure quality health care.

For more information about our Care Management programs, call **1-800-460-5689**.

Durable medical services and durable medical equipment

We cover medically necessary DMS/DME services.

UnitedHeatlhcare Community Plan requires prior authorization for select covered DME/DMS with a retail purchase or cumulative rental cost of more than $500. We must provide authorization for DME and/or DMS within a timely manner so as not to adversely affect the member's health and within 2 business days of receipt of necessary clinical information but not later than 14 calendar days from the date of the initial request. We must pay for any durable medical equipment authorized for members even if delivery of the item occurs within 90 days after the member's disenrollment from UnitedHealthcare Community Plan of Maryland, as long as the member remains Medicaid eligible during the 90-day time period.

We cover disposable medical supplies, including incontinency pants and disposable underpants for medical conditions associated with prolonged urinary or bowel incontinence, if necessary to prevent institutionalization or infection. We cover all DMS/DME used in the administration or monitoring of prescriptions. We pay for breast pumps under certain circumstances in accordance with Medicaid policy.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services

We must cover EPSDT services listed below for members younger than 21 years of age:

- Well-child services provided in accordance with the EPSDT/Healthy Kids periodicity schedule by an EPSDT-certified care provider, including:
  - Periodic comprehensive physical examinations
  - Comprehensive health and developmental history, including an evaluation of both physical and mental health development
  - Immunizations
  - Laboratory tests including blood level assessments
  - Vision, hearing, and oral health screening
  - Health education

The state must also provide or assure the MCO provides expanded EPSDT services and partial or interperiodic well-child services necessary to prevent, treat, or ameliorate physical, mental, or developmental problems or conditions. Services must be sufficient in amount, duration, and scope to treat the identified condition.

All must be covered subject to limitations only based on medical necessity. These include such services as:

- Chiropractic services
- Nutrition counseling
- Private duty nursing services
- Durable medical equipment including assistive devices
- Behavioral health services (Behavioral health services the PCP cannot address are provided through Optum Maryland. Call **1-800-888-1965** for more information.)

Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program. You are responsible for making appropriate referrals for publicly funded programs not covered by Medicaid, including Head Start, the WIC program, Early Intervention services; School Health-Related Special Education Services, vocational rehabilitation, and evidenced based home visiting services provided by community based organizations.

Family planning services

We will cover comprehensive family planning services such as:

- Office visits for family planning services
- Laboratory tests including pap smears
- All FDA-approved contraceptive devices, methods and supplies
- Immediate postpartum Insertion of IUDs
- Oral contraceptives (must allow 12 month supply to be dispensed for refills)
- Emergency contraceptives and condoms without a prescription
- Voluntary sterilization procedures (Sterilization procedures are not self-referred; member must be 21 years of age and must use in-network care provider or have authorization for out-of-network care.)

Gender-affirming services

We cover medically necessary gender-affirming surgery and other somatic care for members with gender incongruence

Habilitation services

We cover habilitation services when medically necessary for certain adults who are eligible for Medicaid under the ACA. These services include: physical therapy, occupational therapy and speech therapy. If you have questions about which adults are eligible call Provider Services at **1-877-842-3210**, Monday – Friday, 8 a.m.-6 p.m. ET.

Home health services

We cover home health services when the member's PCP or ordering care provider certifies that the services are necessary on a part-time, intermittent basis by a member who requires home visits. Covered home health services are delivered in the member's home and include:

- Skilled nursing services including supervisory visits for patients younger than 21 years of age
- Home health aide services (including biweekly supervisory visits by a registered nurse in the member's home, with observation of aide's delivery of services to member at least every other visit)
- Physical therapy services
- Occupational therapy services
- Speech pathology services
- Medical supplies used in a home health visit

Hospice care services

Hospice services can be provided in a hospice facility, in a long-term care facility, or at home. We do not require a hospice care member to change their out of network hospice provider to an in-network hospice provider. Hospice providers should make members aware of the option to change MCOs. MDH will allow new members who are in hospice care to voluntarily change their MCO if they have been auto-assigned to a MCO with whom the hospice provider does not contract. If the new member does not change their MCO, then the MCO, which the new member is currently enrolled must pay the out-of-network hospice provider.

Inpatient hospital services

We cover inpatient hospital services. **UnitedHealthcare Community Plan** is not responsible for payment of any remaining days of a hospital admission that began prior to the individual's enrollment in our MCO. We are

however, responsible for reimbursement of professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

Mobile Integrated Community Health

We cover Mobile Integrated Health services provided by approved EMS agencies for eligible adults.

Nursing facility services

For members enrolled in **UnitedHealthcare Community Plan** prior to admission to a nursing facility, chronic hospital or chronic rehabilitation hospital and who meet the state's level of care (LOC) criteria, UnitedHealthcare Community Plan is responsible for up to 90 days of the stay subject to specific rules.

Outpatient hospital services

We cover medically necessary outpatient hospital services. As required by the state, we limit observation stays to 24 hours.

Outpatient rehabilitative services

We cover outpatient rehabilitative services including but not limited to medically necessary physical therapy for adult members. For members under 21, UnitedHealthcare Community Plan of Maryland covers rehabilitative services when the service is part of a home health visit or inpatient hospital stay.

Oxygen and related respiratory equipment

We cover oxygen and related respiratory equipment.

Pharmacy services and copays

We are responsible for most pharmacy services and will expand our drug Formulary to include new products the FDA approves in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. We cover medical supplies or equipment used in the

administration or monitoring of medication prescribed or ordered for a member by a qualifying care provider. Most behavioral health drugs are on the state's Formulary and are the responsibility of the State.

There are no pharmacy copays for children, pregnant members, individuals in nursing facilities or hospice, or birth control. For drugs the state covers, such as behavioral health drugs, pharmacy copays are $1 for generic drugs, preferred brand-name drugs, and HIV/AIDS, and $3 for brand-name drugs. For drugs UnitedHealthcare Community Plan covers, pharmacy copays for adults are $1 for generic and $3 for brand-name drugs.

See **Chapter 4: Medical Management – Pharmacy Benefit Management** for more information.

Plastic and restorative surgery

We cover these services when the service will correct a deformity from disease, trauma, congenital or developmental anomalies or to restore body functions. **The state nor UnitedHealthcare Community Plan does not cover cosmetic surgery to solely improve appearance or mental health.**

Podiatry services

We cover medically necessary podiatry services. We also cover routine foot care for children under age 21 and for members with diabetes or vascular disease affecting the lower extremities.

Pregnancy-related care

Refer to Maternity/Pregnancy/Well Child and the Services for Pregnant and Postpartum Members sections in this manual. Refer all pregnant members to Healthy First Steps by calling **1-800-599-5985**.

UnitedHealthcare Community Plan and you are responsible for providing pregnancy-related services. These include:

- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment form

- Comprehensive prenatal, perinatal and postpartum care (including high-risk specialty care)
- Development of an individualized plan of care based on the risk assessment and modified during the course of care if needed
- Case management services
- Prenatal and postpartum counseling and education
- Basic nutritional education
- Special substance abuse treatment. This includes access to treatment within 24 hours of request and intensive outpatient programs that allow for children to accompany their parent.
- Nutrition counseling by a licensed nutritionist or dietitian for nutritionally high-risk pregnant members
- Appropriate levels of inpatient care, including emergency transfer of pregnant members and newborns to tertiary care centers
- Postpartum home visits
- Referral to the ACCU

The PCP, OB/GYN and UnitedHealthcare Community Plan must refer pregnant members to publicly provided services that may improve pregnancy outcome. Examples of appropriate referrals include the WIC special supplemental nutritional program and the LHD ACCU. Necessary medical information will be supplied to the program for the purpose of making eligibility determinations.

Pregnancy-related care providers will follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic, if possible, notice to member of the prenatal appointment dates and times.

You must:
- Schedule prenatal appointments according to ACOG guidelines
- Provide the initial health visit within 10 days of the request
- Complete the Maryland Prenatal Risk Assessment form – MDH 4850 for each pregnant member and submit it to the LHD in the jurisdiction in which the member lives within 10 days of the initial visit
- Provide EPSDT screening services to pregnant members younger than 21 if you are their PCP, or refer them to their PCP to have these services provided

- Reschedule appointments within 10 days for members who miss prenatal appointments
- Refer to the WIC Program
- Refer pregnant and postpartum members needing substance use care for appropriate substance abuse assessments and treatment services through the Behavioral Health System
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child
- Instruct pregnant member to notify the MCO of their pregnancy and the expected date of delivery after the initial prenatal visit
- Instruct the pregnant member to contact the MCO for assistance in choosing a PCP for the newborn prior to the eighth month of pregnancy
- Document the pregnant member's choice of pediatric care provider in the medical record
- Advise a pregnant member that they should be prepared to name the newborn at birth. This is required for the hospital to complete the "Hospital Report of Newborns," MDH 1184 and get the newborn enrolled in HealthChoice.

Primary behavioral health services

We cover primary behavioral health services, including assessment, clinical evaluation and referral for additional services. The PCP may elect to treat the member, if the treatment, including visits for buprenorphine treatment, falls within the scope of the PCP's practice, training, and expertise. Referrals for behavioral health services can be made by calling the state's ASO at **1-800-888-1965**, Monday – Friday: 8 a.m.-6 p.m.

Specialty care services

Specialty care services provided by a physician or an advanced practice nurse (APN) are covered when services are medically necessary and are outside of the PCP's customary scope of practice. Specialty care services covered under this section also include:

- Services performed by non-physician, non-APN practitioners, within their scope of practice, employed by a physician to assist in the provision of specialty care services, and working under the physician's direct supervision;
- Services provided in a clinic by or under the direction of a physician or dentist; and

- Services performed by a dentist or dental surgeon, when the services are customarily performed by physicians.

A member's PCP is responsible for making the determination, based on our referral requirements, of whether or not a specialty care referral is medically necessary. PCPs must follow our special referral protocol for children with special health care needs who suffer from a moderate to severe chronic health condition which:

- Has significant potential or actual impact on health and ability to function;
- Requires special health care services; and
- Is expected to last longer than 6 months.

A child functioning at 25% or more below chronological age in any developmental area, must be referred for specialty care services intended to improve or preserve the child's continuing health and quality of life, regardless of the services ability to effect a permanent cure.

Telemedicine and remote patient monitoring

We must offer telemedicine and remote patient monitoring to the extent they are covered by the Medicaid FFS Program.

Transplants

We cover medically necessary transplants to the extent the state's fee-for-service program covers them.

Vision care services

We cover medically necessary vision care services. We are required to cover 1 eye examination every 2 years for members age 21 or older; and for members under age 21, we cover at least 1 eye examination every year in addition to EPSDT screening. For members under age 21, we are required to cover 1 pair of eyeglasses per year unless lost, stolen, broken, or no longer vision appropriate; contact lenses, must be covered if eyeglasses are not medically appropriate for the condition. **UnitedHealthcare Community Plan** covers additional vision services for adults. We cover:

- 1 eye examination every 2 years for members 21 or older; or
- For members younger than 21, at least 1 eye examination every year in addition to EPSDT

screening, 1 pair of eyeglasses per year unless lost, stolen, broken or no longer vision appropriate, and contact lenses.

Assignment and reassignment of members

Members can request to change their MCO 1 time during the first 90 days if they are new to the HealthChoice Program as long as they are not hospitalized at the time of the request. They can also make this request within 90 days if they are automatically assigned to an MCO. Members may change their MCO if they have been in the same MCO for 12 or more months. Members may change their MCO and join another MCO near where they live for any of the following reasons at any time:

- If they move to another county where UnitedHealthcare Community Plan does not offer care
- If they become homeless and find that there is another MCO closer to where they live or have shelter which would make getting to appointments easier
- If they or any member of their family have a doctor in a different MCO and the adult member wishes to keep all family members together in the same MCO
- If a child is placed in foster care and the foster care children or the family members receive care by a doctor in a different MCO than the child being placed, the child being placed can switch to the foster family's MCO
- The member desires to continue to receive care from their PCP and the MCO terminated the PCP's contract for one of the following reasons:
  - For reasons other than quality of care
  - The care provider and the MCO cannot agree on a contract for certain financial reasons
  - Their MCO has been purchased by another MCO

Newborns are enrolled in the MCO the birthing parent was enrolled in on the date of delivery and cannot change for 90 days.

Once an individual chooses or is auto-assigned to UnitedHealthcare Community Plan and selects a PCP, UnitedHealthcare Community Plan enrolls the member into that practice and mails them a member ID card. UnitedHealthcare Community Plan will choose a PCP

close to the member's residence if a PCP is not selected.

UnitedHealthcare Community Plan is required to provide PCPs with their rosters on a monthly basis. MCO members may change PCPs at any time. Members can call UnitedHealthcare Community Plan Member Services Monday – Friday 8 a.m.-7 p.m. Eastern Time at **1-800-318-882 (TTY 711)** to change their PCP.

PCPs may see UnitedHealthcare Community Plan members even if the PCP name is not listed on the membership card. As long as the member is eligible on the date of service and the PCP is participating with UnitedHealthcare Community Plan, the PCP may see the UnitedHealthcare Community Plan member. However, UnitedHealthcare Community Plan does request that the PCP assist the member in changing PCPs so the correct PCP is reflected on the membership card.

Assignment to PCP panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the **UHCprovider.com** application on the Provider Portal. The portal requires a unique user name and password combination to gain access.

Each year, PCP panel size is monitored by reviewing PCP to member ratio reports. To update the PCP panel limits, send a written request.

1. Go to **UHCprovider.com**
2. Select Sign In on the top right
3. Log in
4. Click on Community Care

The Community Care Roster has member contact information, clinical information to include HEDIS® measures/Gaps in Care, is in an Excel format with customizable field export options, and can be pulled at the individual practitioner or TIN level. You may also use Document Library for member contact information in a PDF at the individual practitioner level.

You may also find the Document Library user guide at UHCprovider.com > Resources > UnitedHealthcare Provider Portal Resources > Document Library > **Self-Paced User Guide**.

Choosing a PCP

Each enrolled UnitedHealthcare Community Plan member either chooses or is assigned a PCP. The assignment considers the distance to the PCP, the PCP's capacity and if the PCP is accepting new members. UnitedHealthcare Community Plan will assign members to the closest appropriate PCP.

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the member changes the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the request date.

Scheduling initial appointments

HealthChoice members must be scheduled for an initial appointment within 90 days of enrollment, unless one of the following exceptions apply:

- You determine that no immediate initial appointment is necessary because the member already has an established relationship with you
- For children under 21, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) periodicity schedule requires a visit in a shorter time frame. For example, new members up to 2 years of age must have a well-child visit within 30 days of enrollment unless the child already has an established relationship with a care provider and is not due for a well-child visit.
- For pregnant and postpartum members who have not started to receive care, the initial health visit must be scheduled and the member seen within 10 days of a request
- As part of the MCO enrollment process the state asks the member to complete a Health Services Needs Information (HSNI) form. This information is then transmitted to the MCO. A member who has an identified need must be seen for their initial health visit within 15 days of UnitedHealthcare Community Plan's receipt of the HSNI.
- During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age-appropriate physical exam
- In addition, at the initial health visit, initial prenatal

visit, or when a member's physical status, behavior or laboratory findings indicate possible substance use disorder, you must refer the member to the Behavioral Health System at **1-800-888-1965**

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary health care services or supplies are medically appropriate and:

- Necessary to meet members' basic health needs
- Cost-efficient and appropriate for the covered services

Member assignment

Assignment to UnitedHealthcare Community Plan

MDH assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. MDH makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end, but at times may occur mid-month.

At enrollment time, each member receives a welcome packet that includes a copy of the UnitedHealthcare Community Plan Member Handbook. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

Download a copy of the Member Handbook online at **UHCCommunityPlan. com/MD**. Go to Plan Details, then Member Resources, View Available Resources.

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for members, including newborns,

may change from Fee for Service (FFS) to Medicaid Managed Care during hospitalization. To avoid delays in claims processing and payment, check the payer assignment of newborns daily.

> Get eligibility information by calling **Provider Services**.

> UnitedHealthcare Community Plan Members can go to **myuhc.com/communityplan** to look up a care provider.

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with HealthChoice, Maryland's Medicaid program. The MDH determines program eligibility. An individual who becomes eligible for the HealthChoice program either chooses or is assigned to one of the MDH-contracted health plans.

Verifying member enrollment

Verify member eligibility prior to providing services.

Determine eligibility in the following ways:

- Provider Portal: access the portal through **UHCprovider.com/eligibility**
- UnitedHealthcare Provider Services is available from 8 a.m.-6 p.m. Eastern, Monday through Friday
- EVS at **1-866-710-1447**

Member ID card

Check the member's ID card at each visit, and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license, if this is your office practice.

> If a fraud, waste and abuse event arises from a care provider or a member, report it at **uhc.com/fraud**. Or you may call the **Fraud, Waste, and Abuse Hotline**.

The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call Provider Services. Also document the call in the member's chart.

Member identification numbers

Each member receives a 9-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The MDH Medicaid Number is also on the member ID card.

Sample health member ID card

Care provider-requested member transfer

When persistent problems prevent an effective care provider-patient relationship, a participating care provider may ask a member to leave their practice. Such

requests cannot be based solely on the member filing a grievance, an appeal, a request for a Fair Hearing or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

The following steps must be taken when requesting a specific care provider-patient relationship termination:

- You must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:

  > **UnitedHealthcare Community Plan of Maryland**
  > 10175 Little Patuxent Parkway
  > Columbia, MD 21044

- You must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care

- Upon request, you will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new care provider upon receipt of a signed patient authorization

UnitedHealthcare Dual Complete (D-SNP)

UnitedHealthcare Dual Complete (D-SNP) is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For general information about D-SNP, go to **uhc.com/medicaid/dsnp**.

For information about UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. For Maryland-specific DSNP information, go to **UHCprovider.com/en/health-plans-by-state/maryland-health-plans/md-medicare-plans/md-dual-complete-snp-plans.html**.

Chapter 4: Medical Management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > **Referrals**	1-877-842-3210
Prior Authorization	**UHCprovider.com/paan**	
Pharmacy	**professionals.optumrx.com**	
Healthy First Steps	**uhchealthyfirststeps.com**	1-800-599-5985

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Medical management improves the quality and outcome of health care delivery. We offer the following services as part of our medical management process.

MCO member outreach and support services

Outreach efforts to bring the enrollee into care must be documented in the medical record. These efforts may include, but may not be limited to, attempts to notify the enrollee by mail, telephone and through face-to-face contact.

- Within 10 days of either the second consecutive missed appointment, or of the member's care provider becoming aware of the patient's repeated noncompliance with a regimen of care, whichever occurs first, you will make a written referral to the LHD Administrative Care Coordination Unit (ACCU) using the Local Health Services Request Form requesting its assistance in locating and contacting the enrollee for the purpose of encouraging the enrollee to seek care
- After referral to the ACCU, you will work with the ACCU and UnitedHealthcare Community Plan to bring the enrollee into care

Maryland continuity of care provisions

Under Maryland Insurance law, HealthChoice members have certain continuity of care rights. These apply when the member: is new to the HealthChoice Program; has switched from another company's health benefit plan; or has switched to **UnitedHealthcare Community Plan** from another MCO.

The following services are excluded from Continuity of Care for HealthChoice members:
- Dental services
- Mental health services
- Substance use disorder services
- Benefits or services provided through the Maryland Medicaid fee-for-service program

Prior authorization for health care services

If the previous MCO or company preauthorized services, we will honor the approval if the member calls **1-800-318-8821** (**TTY 711**) Monday – Friday, 8 a.m.-7 p.m. EST. Under Maryland law, insurers must provide a copy of the prior authorization within 10 days of the member's request. There is a time limit for how long we must honor this prior authorization. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date

the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health practitioner after the baby is born.

Right to use non-participating care providers

Members can contact us to request the right to continue to see a non-participating provider. This right applies only for one or more of the following types of conditions:

- Acute conditions
- Serious chronic conditions
- Pregnancy
- Any other condition upon which we and the out-of-network care provider agree

There is a time limit for how long we must allow the member to receive services from an out of network provider. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care provider after the baby is born.

If the member has any questions, they should call **UnitedHealthcare Community Plan** Member Services at **1-800-318-8821 (TTY 711)** Monday – Friday, 8a.m.-7p.m. EST or the state's HealthChoice Help Line at 800-284-4510.

State support services

The state provides grants to local health departments to operate Administrative Care Coordination/Ombudsman services (ACCUs) to assist with outreach to certain non-complaint members and special populations as outlined below. MCOs and care providers are encouraged to develop collaborative relationships with the local ACCU. See Attachment #3 for the local ACCU contact information. If you have questions call the Division of Community Liaison and Care Coordination at **1-410-767-6750**, which oversees the ACCUs or the HealthChoice Provider Help Line at **1-800-766-8692**.

State-designated special populations

The state has identified certain groups as requiring special clinical and support services from their MCO. These special needs populations are:

- Pregnant and postpartum members
- Children with special health care needs
- Children in state-supervised care
- Individuals with HIV/AIDS
- Individuals with a physical disability
- Individuals with a developmental disability
- Individuals who are homeless

To provide care to a special needs population, it is important for the PCP and specialist to:

- Demonstrate their credentials and experience to us in treating special populations
- Collaborate with our case management staff on issues pertaining to the care of a special needs member
- Document the plan of care and care modalities and update the plan annually

Individuals in one or more of these special needs populations must receive services in the following manner from us and/or our care providers:

- Upon the request of the member or the PCP, a case manager trained as a nurse or a social worker will be assigned to the member. The case manager will work with the member and the PCP to plan the treatment and services needed. The case manager will not only help plan the care, but will help keep track of the health care services the member receives during the year and will serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and our case managers, when required, coordinate referrals for needed specialty care. This includes specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. **PCPs should follow the referral protocols established by us for sending HealthChoice members to specialty care networks.**
- We have a special needs coordinator on staff to focus on the concerns and issues of special needs populations. The special needs coordinator helps members find information about their condition or

suggests places in their area where they may receive community services and/or referrals. To contact the special needs coordinator, call **1-800-460-5689**.

- You are required to treat individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 (P.L. 101-336 42 U.S.C. 12101 et. seq. and regulations promulgated under it).

Special needs population - outreach and referral to the LHD

A member of a special needs population who fails to appear for appointments or who has been non-compliant with a regimen of care must be referred to UnitedHealthcare Community Plan. If a member continues to miss appointments, call **UnitedHealthcare Community Plan** at 800-460-5689. We will attempt to contact the member by mail, telephone and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the LHD ACCU. You may also make a written referral to the ACCU by completing the Local Health Services Request Form. **See Attachment #4** or **mmcp.health.maryland.gov**). The local ACCU staff will work collaboratively with **UnitedHealthcare Community Plan** to contact the member and encourage them to keep appointments and provide guidance on how to effectively use their Medicaid/HealthChoice benefits.

Services for pregnant and postpartum members

Prenatal care providers are key to assuring that pregnant members have access to all available services. Many pregnant members will be new to HealthChoice and will only be enrolled in Medicaid during pregnancy and the postpartum period. Medicaid provides full benefits to these members during pregnancy and for 1 year after delivery after which they will automatically be enrolled in the Family Planning Waiver Program. (For more information visit: **health.maryland.gov/mmcp/Documents/Factsheet3_Medicaid%20Family%20Planning%20Program.pdf**.)

UnitedHealthcare Community Plan and our care providers are responsible for providing pregnancy-related services, which include:

- Comprehensive prenatal, perinatal, and postpartum care (including high-risk specialty care)
- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment form (MDH 4850) (For updated form, visit **https://health.maryland.gov/mmcp/Documents/Maryland%20Prenatal%20Risk%20Assesment%20-%20Revised%2010.4.22.pdf**)
- An individualized plan of care based upon the risk assessment and which is modified during the course of care as needed
- Appropriate levels of inpatient care, including emergency transfer of pregnant members and newborns to tertiary care centers
- Case management services
- Prenatal and postpartum counseling and education including basic nutrition education
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant members
- Doula support for prenatal visits, attendance at labor and delivery, and postpartum visits
- Prenatal, postpartum, and infant home visits from pregnancy and childbirth up to 2-3 years of the child's age

The state provides these additional services for pregnant members:

- Special access to substance use disorder treatment within 24 hours of request and intensive outpatient programs that allow for children to accompany their parent

Encourage all pregnant members to call the state's Help Line for Pregnant Woman at **1-800-456-8900**. This is especially important for members who are newly eligible or not yet enrolled in Medicaid. If the member is already enrolled in HealthChoice, call us and also instruct them to call our Healthy First Steps Program at **1-800-599-5985, TTY 711**, 8 a.m.–5 p.m., Monday through Friday.

Pregnant members who are already under the care of an out-of-network practitioner qualified in obstetrics may continue with that practitioner if they agree to accept payment from **UnitedHealthcare Community Plan**. If the practitioner is not contracted with us, a care manager and/or Member Services representative will coordinate services necessary for the practitioner to continue the member's care until postpartum care is completed.

The prenatal care providers must follow, at a minimum,

the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic, if possible, notice to member of the prenatal appointment dates and times. The prenatal care provider, PCP and UnitedHealthcare Community Plan are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcomes. Examples of an appropriate referral include the Women Infants and Children special supplemental nutritional program (WIC).

Prenatal care providers are also required to:

- Provide the initial health visit within 10 days of the request
- Complete the Maryland Prenatal Risk Assessment form-MDH 4850. **See Attachment #5** during the initial visit and submit it to the Local Health Department within 10 days of the initial visit. UnitedHealthcare Community Plan will pay for the initial prenatal risk assessment — use CPT code H1000.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child
- At each visit provide health education relevant to the member's stage of pregnancy. UnitedHealthcare Community Plan will pay for this — use CPT code H1003 for an "Enriched Maternity Services" — You may only bill for 1 unit of "Enriched Maternity Services" per visit. Refer pregnant and postpartum members to the WIC Program.
- If under the age 21, refer the member to their PCP to have their EPSDT screening services provided
- Reschedule appointments within 10 days if a member misses a prenatal appointment. Call UnitedHealthcare Community Plan if a prenatal appointment is not kept within 30 days of the first missed appointment.
- Refer pregnant members to the Maryland Healthy Smiles Dental Program. Members can contact Healthy Smiles at **1-855-934-9812**; TDD: **1-855-934-9816**; Web portal: **member.mdhealthysmiles.com** if you have questions about dental benefits.
- Refer pregnant and postpartum members in need of diagnosis and treatment for a mental health or substance use disorder to the Behavioral Health System; if indicated they are required to arrange for substance abuse treatment within 24 hours

- Educate pregnant members on doula services or refer eligible members for home visits if medically necessary and appropriate
- Record the member's choice of pediatric care provider in the medical record prior to their eighth month of pregnancy. We can assist in choosing a PCP for the newborn. Advise the member that they should be prepared to name the newborn at birth. This is required for the hospital to complete the "Hospital Report of Newborns", MDH 1184. (The hospital must complete this form so Medicaid can issue the newborns ID number.) The newborn will be enrolled in the postpartum member's MCO.

Childbirth-related provisions

Special rules for length of hospital stay following childbirth:

A member's length of hospital stay after childbirth is determined in accordance with the ACOG and AAP Guidelines for perinatal care unless the 48-hour (uncomplicated vaginal delivery)/96-hour (uncomplicated cesarean section) length of stay guaranteed by state law is longer than that required under the guidelines.

If a member must remain in the hospital after childbirth for medical reasons, and the member requests that their newborn remain in the hospital while they are hospitalized, additional hospitalization of up to 4 days is covered for the newborn and must be provided.

If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by state law, a home visit must be provided. When a member opts for early discharge from the hospital following childbirth, (before 48 hours for vaginal delivery or before 96 hours for C-section) 1 home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending care provider, are covered.

Postnatal home visits must be performed by a registered nurse, in accordance with generally accepted standards of nursing practice for home care of a postpartum member and newborn, and must include:

- An evaluation to detect immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress or other adverse symptoms of the newborn

- An evaluation to detect immediate problems of dehydration, sepsis, infection, bleeding, pain or other adverse symptoms of the postpartum member Blood collection from the newborn for screening, unless previously completed
- Appropriate referrals; and any other nursing services ordered by the referring care provider

If the member remains in the hospital for the standard length of stay following childbirth, a home visit, if the care provider prescribes, is covered.

Unless we provide for the service prior to discharge, a newborn's initial evaluation by an out-of-network on-call hospital physician before the newborn's hospital discharge is covered as a self-referred service.

We are required to schedule the newborn for a follow-up visit within 2 weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit. Breast pumps are covered under certain situations for breastfeeding members. Call us at **1-800-599-5985**.

Children with special health care needs

Self-referral for children with special needs is intended to ensure continuity of care and appropriate plans of care. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in **UnitedHealthcare Community Plan**. Medical services directly related to a special needs child's medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

New member – A child who, at the time of initial enrollment, was receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing out-of-network care provider submits the plan of care to us for review and approval within 30 days of the child's effective date of enrollment into UnitedHealthcare Community Plan and we approve the services as medically necessary.

Established member – A child who is already enrolled in **UnitedHealthcare Community Plan** when diagnosed

as having a special health care need requiring a plan of care that includes specific types of services may request a specific out-of-network care provider. We are obliged to grant the member's request unless we have a local in-network specialty care provider with the same professional training and expertise who is reasonably available and provides the same services and service modalities.

If we deny, reduce, or terminate the services, members have an appeal right, regardless of whether they are a new or established member. Pending the outcome of an appeal, we may reimburse for services provided.

For children with special health care needs, **UnitedHealthcare Community Plan** will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure
- Provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions, social services, or both, a multi-disciplinary team must be used to review and develop the plan of care for children with special health care needs.
- Refer special needs children to specialists as needed. This includes specialty referrals for children who have been found to be functioning one-third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
- Allow children with special health care needs to access out-of-network specialty care providers under certain circumstances. We log any complaints made to the state or to **UnitedHealthcare Community Plan** about a child who is denied a service by us. We will inform the state about all denials of service to children. All denial letters sent to children or their representative will state that members can appeal by calling the state's HealthChoice Help Line at **1-800-284-4510**.
- Work closely with the schools that provide education and family services programs to children with special needs

Children in state-supervised care

We will ensure coordination of care for children in state-supervised care. If a child in state-supervised care moves out of the area and must transfer to another MCO, the state and UnitedHealthcare Community Plan will work together to find another MCO as quickly as possible.

Individuals with HIV/AIDS

We are required to provide the following services for persons with HIV/AIDS:

- An HIV/AIDS specialist is provided for treatment and coordination of primary and specialty care
- A diagnostic evaluation service (DES) assessment can be performed once every year at the member's request. The DES includes a physical, mental and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES for the evaluation.
- Substance use disorder treatment is provided within 24 hours of request
- The right to ask us to send them to a site doing HIV/AIDS related clinical trials. We may refer members who are individuals with HIV/AIDS to facilities or organizations that can provide the members with access to clinical trials.
- You will maintain the confidentiality of client records and eligibility information, in accordance with all federal, state, and local laws and regulations, and use this information only to assist the participant in receiving needed health care services

UnitedHealthcare Community Plan provides case management services for any member who is diagnosed with HIV. We provide these services with the member's consent and will facilitate timely and coordinated access to appropriate levels of care and support continuity of care across the continuum of qualified service providers. If a member initially refuses HIV case management services, they may request services at a later time. The member's case manager serves as the member's advocate to resolve differences between the member and care providers pertaining to the course or content of therapeutic interventions.

Individuals with physical or developmental disabilities

Care providers who treat individuals with physical or developmental disabilities must be trained on the special communications requirements of individuals with physical disabilities. We are responsible for accommodating hearing impaired members who require and request a qualified interpreter. We can delegate the financial risk and responsibility to our providers, but we are ultimately responsible for ensuring that our members have access to these services.

Before placement of an individual with a physical disability into an intermediate or long-term care facility, we will cooperate with the facility in meeting their obligation to complete a Pre-admission Screening and Resident Review (PASRR) ID Screen.

Homeless individuals

Homeless individuals may use the local health department's address to receive mail. If we know an individual is homeless, we offer to provide a case manager to coordinate health care services.

If a member is homeless, our special needs coordinator can help them access to health care services and psychosocial support. The coordinator will identify any additional community programs and support services (where available) that may benefit the member. Call 800-460-5689 for information.

Refer members with substance abuse issues, including pregnant members, to the Maryland Public Behavioral Health System at **1-800-888-1965**.

Rare and Expensive Case Management Program

The **Rare and Expensive Case Management (REM) Program** is an alternative to managed care for children and adults with certain diagnosis who would otherwise be required to enroll in HealthChoice. If the member is determined eligible for REM they can choose to stay in UnitedHealthcare Community Plan or they may receive

services through the traditional Medicaid fee-for-service program. They cannot be in both an MCO and REM. **See Attachment #1** for the list of qualifying diagnosis and a full explanation of the referral process.

State NEMT assistance

If a member needs transportation assistance, contact the LHD to assist members in accessing nonemergency medical transportation services (NEMT). UnitedHealthcare Community Plan will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD. **See Attachment #3 for NEMT contact information.**

MCO transportation assistance

Under certain circumstances, UnitedHealthcare Community Plan may provide limited transportation assistance when members do not qualify for NEMT through the LHD.

Self-referral and emergency services

Members have the right to access certain services without prior referral or authorization by a PCP. We are responsible for reimbursing out-of-plan care providers who have furnished these services to our members.

The state allows members to self-refer to out of network care providers for the services listed below. **UnitedHealthcare Community Plan** will **pay out of plan providers** the state's Medicaid rate for the following services:

- Emergency services provided in a hospital emergency facility and medically necessary post-stabilization services
- Family planning services excluding sterilizations
- Maryland school-based health center services. School-based health centers are required to send a medical encounter form to the child's MCO. We will forward this form to the child's PCP, who will be responsible for filing the form in the child's medical record. See **Attachment #2** for a sample School Based Health Center Report Form;

- Pregnancy-related services when a member has begun receiving services from an out-of-plan care provider prior to enrolling in an MCO
- Initial medical examination for children in state custody (Identified by Modifier 32 on the claim)
- Annual diagnostic and evaluation services for members with HIV/AIDS
- Renal dialysis provided at a Medicare-certified facility
- The initial examination of a newborn by an on-call hospital physician when we do not provide for the service prior to the baby's discharge
- Services performed at a birthing center
- Children with special health care needs may self-refer to care providers outside of **UnitedHealthcare Community Plan's** network under certain conditions. See Section II for additional information

If you contract with **UnitedHealthcare Community Plan** for any of the services listed, you must follow our billing and prior authorization procedures. Reimbursements will be paid the contracted rate.

Cardiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for cardiology procedures.

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures (including inpatient)
- Echocardiograms
- Stress echocardiograms

Cardiology procedures do not require prior authorization if performed in the following places of service:

- ER
- Observation unit
- Urgent care
- Inpatient stay (except for electrophysiology implants).

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone:

- **Online – UHCprovider.com/cardiology** > select the Go to Prior Authorization and Notification Tool
- **Phone – 1-866-889-8054** from 7 a.m.-7 p.m., Monday through Friday.

Make sure the medical record is available.

For the most current list of CPT codes that require prior authorization, a prior authorization crosswalk, and or the evidence-based clinical guidelines, go to **UHCprovider. com/cardiology** > Specific Cardiology Programs.

Emergency/urgent care services

Emergency services do not require prior authorization.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate ER use. A PCP should treat nonemergency services such as sprains/strains, stomachaches, earaches, fever, coughs, colds and sore throats.

Covered services include:

- Hospital emergency department room, ancillary and care provider service by in and out-of-network care providers
- Medical examination
- Stabilization services
- Access to designated Level I and Level II trauma centers or hospitals meeting the same levels of care for emergency services

Emergency room care

For an emergency, the member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No referral is needed. Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.

Before they are treated, UnitedHealthcare Community Plan members who visit an emergency room are screened to determine whether they have a medical emergency. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan covers these services regardless of the emergency care

provider's relationship with UnitedHealthcare Community Plan.

Urgent care (nonemergent)

Urgent care services are covered.

> For a list of urgent care centers, contact **Provider Services**.

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

> Emergency care should be delivered without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool at **UHCprovider.com/paan**, EDI 278N transaction at **UHCprovider.com/edi**, or call Provider Services.

UnitedHealthcare Community Plan uses evidence-based, nationally accredited, clinical criteria for determinations of appropriateness of care. UnitedHealthcare Community Plan does not reward for denials.

> The criteria are available in writing upon request or by calling **Provider Services**.

If a member meets an acute inpatient level of stay, admission starts when you write the order.

Care coordination/ health education

Our care coordination program is led by our qualified, full-time care coordinators. You are encouraged to collaborate with us to ensure care coordination services are provided to members. This program is a proactive approach to help members manage specific conditions

and support them as they take responsibility for their health.

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with care providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes
- Support member empowerment and informed decision making
- Effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

Our program makes available population-based, condition-specific health education materials, websites, interactive mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based upon evidence-based guidelines or standards of care, directly to members that address topics that help members manage their condition. Our program provides personalized support to members in case management. The case manager collaborates with the member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the care coordination program.

Programs are based upon the findings from our Health Education, Cultural and Linguistic Group Needs Assessment (GNA) and will identify the health education, cultural and linguistic needs.

Home health program

Home health services are covered when the member's PCP or attending care provider certifies that the services

are necessary on a part-time, intermittent basis by a member who requires home visits. Covered home health services are delivered in the member's home and include:

- Skilled nursing services, including supervisory visits
- Home health aide services (including biweekly supervisory visits by a registered nurse in the member's home, with observation of aide's delivery of services to the member at least every other visit)
- Physical therapy services
- Occupational therapy services
- Speech pathology services
- Medical supplies used in a home health visit

Laboratory

Use UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office. For more information on our in-network labs, go to UHCprovider.com > Our Network > **Preferred Lab Network**. Medically necessary laboratory services ordered by a PCP, other care providers or dentist in one of these laboratories do not require prior authorization except as noted on our prior authorization list.

When submitting claims, have a Clinical Laboratory Improvement Amendment number (CLIA #). Otherwise, claims will deny. CLIA standards are national and not Medicaid-exclusive. CLIA applies to all providers rendering clinical laboratory and certain other diagnostic services.

See the Billing and Encounters chapter for more information.

Maternity/pregnancy/ well-child care

Pregnancy notification risk screening

Notify UnitedHealthcare Community Plan immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program.

Access the digital Notification of Pregnancy form through the Provider Portal at **UHCprovider.com**. You may also call Healthy First Steps at **1-800-599-5985**.

HFS-maternal care model

The HFS-Maternal care model strives to:
- Increase early identification of expectant members and facilitate case management enrollment
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care.
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Multidisciplinary support for pregnant members to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed health care decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings
- Encourage members to stop smoking with our Quit for Life tobacco program
- Help identify and build the mother's support system including referrals to community resources and pregnancy support programs
- Program staff act as a liaison between members, care providers and United Healthcare for care coordination

Pregnancy/maternity

Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan care providers only. UnitedHealthcare Community Plan considers exceptions to this policy if:

1. the member was pregnant when they became a UnitedHealthcare Community Plan member and
2. If they have an established relationship with a nonparticipating obstetrician willing to bill and accept payment from UnitedHealthcare Community Plan

Notify UnitedHealthcare Community Plan immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program.

A UnitedHealthcare Community Plan member does not need a referral from her PCP for OB/GYN care.

Maternity admissions

All maternity admissions require notification. Days in excess of 48 hours for vaginal deliveries and 96 hours for C-section require clinical information and medical necessity review.

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/paan**, or by calling Provider Services.

Provide the following information within 1 business day of the admission:
- Date of admission
- Member's name and Medicaid ID number
- Obstetrician's name, phone number and care provider ID
- Facility name (care provider ID)
- Vaginal or Caesarean delivery

If available at time of notification, provide the following birth data:
- Date of delivery
- Sex
- Birth weight
- Gestational age
- Baby name

Nonroutine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after mother's discharge require separate notification and will be subject to medical necessity review. The midwife (CNM) must be a licensed registered nurse recognized by the Board of Nurse Examiners as

an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives.

A CNM must identify a licensed care provider or group of care providers with whom they have arranged for referral and consultation if complications arise.

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through an NP, PA or licensed professional nurse. If handled through supervision, the services must be within the staff's scope of practice or licensure as defined by state law.

You do not have to be present when services are provided. However, you must assume professional responsibility for the medical services provided and help ensure approval of the care plan.

NICU case management

The Neonatal Intensive Care Unit (NICU) Management program manages inpatient and post-discharge NICU cases to improve outcomes and lower costs. Our dedicated team of NICU case managers, social workers and medical directors offer both clinical care and psychological services.

The NICU Case Management program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth. High-risk newborns placed in the NICU are eligible upon birth for NICU Case Management services.

The NICU Case Management team works closely with Neonatal Resource Services (NRS) team neonatologist and Utilization Management nurses, health plan registered nurses and social worker care managers to support and coordinate needed care for NICU infants and their families, as appropriate.

Inhaled nitric oxide

Use the NRS guideline for inhaled nitric oxide (iNO) therapy at UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > **Clinical Guidelines**.

Radiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for radiology procedures.

You must obtain prior authorization for the following advanced imaging procedures if you provide them in an office or outpatient setting.

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron-emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

Advanced imaging procedures do not require prior authorization if performed in the following places of service:

- ER
- Observation unit
- Urgent care
- Inpatient stay

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone at:

- **Online – UHCprovider.com/radiology** > Go to Prior Authorization and Notification Tool
- **Phone – 1-866-889-8054** from 7 a.m.–7 p.m. Eastern Time, Monday through Friday. Make sure the medical record is available. An authorization number is required for each CPT code.

For a list of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, go to **UHCprovider.com/radiology** > Specific Radiology Programs.

Out-of-network care providers

When approving or denying a service from an out-of-network care provider, UnitedHealthcare Community Plan will assign a prior authorization number, which refers to and documents the approval. UnitedHealthcare Community Plan sends written documentation of the approval or denial to the out-of-network care provider within the time frames appropriate to the type of request. Refer to our list of self-referred services, which are services we must allow members to access out-of-network. Occasionally, a member may be referred to an out-of-network care provider because of special needs and the out-of-network care provider's qualifications. UnitedHealthcare Community Plan makes such decisions on a case-by-case basis.

Pharmacy benefit management

UnitedHealthcare Community Plan is responsible for most pharmacy services and will expand our drug formulary to include new products approved by the FDA in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program for prescription medications and certain over-the-counter medicines. This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high risk and special needs populations and vaccines prescribed to protect individuals against vaccine-preventable diseases. If a generic equivalent is not available, a new brand-name drug the FDA rates as P (priority) will be added to the formulary.

Coverage may be subject to prior authorization to ensure medical necessity for specific therapies. For formulary drugs requiring prior authorization, a decision will be provided within 24 hours of request. When a prescriber believes that a non-formulary drug is medically indicated, we have procedures in place for non-formulary requests. The state expects a non-formulary drug to be approved if documentation is provided indicating that the formulary alternative is not medically appropriate. Requests for non-formulary drugs will not be automatically denied or delayed with repeated requests for additional information.

Pharmaceutical services and counseling ordered by an in-plan care provider, by a care provider to whom the member has legitimately self-referred (if provided on-site), or by an emergency medical care provider are covered, including:

- Legend (prescription) drugs
- Insulin
- All FDA-approved contraceptives (we may limit which brand drugs we cover)
- Latex condoms and emergency contraceptives (to be provided without any requirement for a care provider's order)
- Non-legend ergocalciferol liquid (Vitamin D)
- Hypodermic needles and syringes
- Enteral nutritional and supplemental vitamins and mineral products given in the home by nasogastric, jejunostomy, or gastrostomy tube
- Enteric-coated aspirin prescribed for treatment of arthritic conditions
- Non-legend ferrous sulfate oral preparations
- Non-legend chewable ferrous salt tablets when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in formulation, for members under age 12
- Formulas for genetic abnormalities
- Medical supplies for compounding prescriptions for home intravenous therapy

The following are not covered by the state or the MCO:

- Prescriptions or injections for central nervous system stimulants and anorectic agents when used for controlling weight
- Non-legend drugs other than insulin and enteric aspirin ordered for treatment of an arthritic condition
- Medications for erectile dysfunction
- Ovulation stimulants

UnitedHealthcare Community Plan contracts with **OptumRx** to provide the following services: pharmacy network contracting and network Point-of-Sale (POS) claim processing.

Mail order prescriptions

Mail order is available and part of the pharmacy benefit. It requires the member's or their appointed/authorized representative's consent before the medications can be

delivered. UnitedHealthcare Community Plan contracts with Optum Home Delivery for this service.

Specialty pharmacy services

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has one or more of the following characteristics:

- Is used by a small number of people
- Treats rare, chronic, and/or potentially life-threatening diseases
- Has special storage or handling requirements such as needing to be refrigerated
- May need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- May not be available at retail pharmacies
- May be oral, injectable or inhaled

Specialty pharmacy medications are available through our specialty pharmacy network.

For specialty pharmacy services, **UnitedHealthcare Community Plan** contracts with **OptumRx**.

UnitedHealthcare Community Plan is responsible for formulary development, drug utilization review, and prior authorization. **UnitedHealthcare Community Plan's** drug utilization review program is subject to review and approval by MDH and is coordinated with the drug utilization review program of the Behavioral Health Service delivery system.

For more information about specialty pharmacy medications, go to **UHCprovider.com/en/prior-auth-advance-notification/prior-auth-specialty-drugs.htm**l.

Prescription and drug Formulary

Check the current **UnitedHealthcare Community Plan** Formulary, **UnitedHealthcare Community Plan Maryland HealthChoice Preferred Drug List**, before writing a prescription for either prescription or over-the-counter drugs **UnitedHealthcare Community Plan**. Members must have their prescriptions filled at a network pharmacy.

Most behavioral health medications are paid by Medicaid

not the MCO. The state's Medicaid Formulary can be found at: **client.formularynavigator.com**

Prescription copays

There are no copays for children under 21, pregnant members, individuals in a nursing facility or hospice, or for family planning. For drugs UnitedHealthcare Community Plan covers, pharmacy copays for adults are $1 for generic and $3 for brand drugs.

Over-the-counter products

UnitedHealthcare Community Plan covers certain over-the-counter (OTC) products. A member needs a prescription to benefit from this program. Covered OTC products include acne products, antifungals, antacids, cough and cold remedies, pain products, and vitamins.

Injectables and non-Formulary medications requiring prior authorization

For a current listing, go to UHCprovider.com/MDcommunityplan > **Pharmacy Resources and Physician Administered Drugs** for all information.

Prior authorization process

Pharmacy services

UnitedHealthcare Community Plan has an extensive pharmacy program, including a PDL and pharmaceutical management procedures.

Medically necessary outpatient prescription drugs are covered when prescribed by a care provider licensed to prescribe federal legend drugs or medicines. Some items are covered only with prior authorization as outlined in our PDL. To view and search the PDL, PDL updates and pharmacy management procedures, go to Pharmacy Program at UHCprovider.com/

MDcommunityplan > **Pharmacy Resources and Physician Administered Drugs** or access using the PreCheck MyScript application.

When a care provider believes that a non-Formulary drug is medically indicated, we have procedures for non-Formulary requests (COMAR 10.67.06.04F(2)(a)). We require prior authorization. We also review the drug for medical necessity. The state expects a non-Formulary drug to be approved if documentation is provided indicating that the formulary alternative is not medically appropriate. Requests for non-Formulary drugs will not be automatically denied or delayed with repeated requests for additional information. We provide a decision within 24 hours of the request receipt.

Benefits for opioids

Per state requirements, UnitedHealthcare Community Plan has implemented a prior authorization requirement for opioid prescriptions exceeding a 90 morphine milligram equivalent (MME) cumulative dosage. All long-acting opioid medications require a prior authorization. Prior authorization criteria are aligned with the Centers for Disease Control and Prevention's (CDC's) recommendations for the treatment of chronic non-cancer pain. The CDC guidelines on long-acting opioids are found at **cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm**.

Use these resources to help manage your members with chronic pain:

- Maryland Department of Health Opioid Drug Utilization Review: **mmcp.health.maryland.gov** > HealthChoice > Opioid DUR Workgroup
- National Center for Biotechnology Information: **ncbi.nlm.nih.gov**. Search for "Interventions in the Management of Patients with Chronic Pain"

Screening tools

- Pain Assessment Scale: **health.gov**

Treatment helpline

- Free, confidential service for our members. Specialized licensed clinicians provide treatment advocate services 24 hours a day, 7 days a week.
- **Phone –** 1-855-780-5955

- **Website** – **liveandworkwell.com**

If you have any additional questions, call **1-888-362-3368**.

Limitations

Neither the state nor the MCO cover the following:

- Prescriptions or injections for central nervous system stimulants and anorectic agents when used for controlling weight
- Nonlegend drugs other than insulin and enteric aspirin ordered for treatment of an arthritic condition
- Except for specialty drugs, members are not required to use mail-order pharmacy providers. If a specialty drug is available in a community pharmacy, and a member requests to obtain the prescription through the community care provider, we will honor the request.

We follow the state's medical criteria for coverage of Hepatitis C drugs.

Step therapy and quantity limits

UnitedHealthcare Community Plan applies automated prerequisite step therapy criteria and quantity limit edits to certain medications. Step therapy edits are clinically appropriate and have cost-effective alternatives for the member's condition. Quantity limit edits follow FDA-approved guidelines and protects members from high doses.

The Pharmacy and Therapeutics Committee established criteria for step therapy and quantity limit edits that follow evidence-based review principles. These principles include current literature reviews, consultation with practicing physicians and pharmacists. These experts work in the plan's service area and possess a wide range of specialized medical expertise, government agency policies (i.e., FDA), and national accreditation organization standards. They update criteria at least annually and when new evidence becomes available.

When you prescribe a step therapy drug, but the member does not meet the step therapy criteria, we require prior authorization. We also require prior authorization for monthly prescriptions with quantities greater than the indicted limit.

View a complete list of medications with step therapy and quantity limits in the UnitedHealthcare Community Plan PDL at **UHCprovider.com**. The list marks step therapy drugs with a "ST." It lists quantity limit drugs with a "QL."

Maryland Prescription Drug Monitoring Program

UnitedHealthcare Community Plan complies with the Maryland Prescription Drug Monitoring Program (PDMP). The Maryland PDMP is an important component of the Maryland Department of Health initiative to halt the abuse and diversion of prescription drugs. The Maryland Department of Health is a statewide database that collects prescription data on Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH) dispensed in outpatient settings. The Maryland Department of Health does not collect data on any other drugs.

Pharmacies must submit data to the Maryland Department of Health at least once every 15 days. This requirement applies to pharmacies that dispense CDS or HGH in outpatient settings in Maryland, and by out-of-state pharmacies dispensing CDS or HGH into Maryland. Patient information in the Maryland Department of Health is intended to help prescribers and pharmacists provide better-informed patient care. The information will help supplement patient evaluations, confirm patients' drug histories, and document compliance with therapeutic regimens.

New registration access to the Maryland Department of Health database at **crisphealth.org** is granted to prescribers and pharmacists who are licensed by the state of Maryland and in good standing with their respective licensing boards. Prescribers and pharmacists authorized to access the Maryland Department of Health, must certify before each search that they are seeking data solely for the purpose of providing healthcare to current patients. Authorized users agree that they will not provide access to the Maryland Department of Health to any other individuals, including members of their staff.

Corrective Managed Care Program

We restrict members to one pharmacy if they have abused pharmacy benefits. We must follow the state's criteria for Corrective Managed Care. The Corrective Managed Care (CMC) Program is an ongoing effort by the Maryland Medicaid Pharmacy Program (MMPP) to monitor and promote appropriate use of controlled substances. Call **Member Services at 1-800-318-8821 (TTY 711), Monday – Friday, 8 a.m.-7 p.m.** if a member is having difficulty filling a prescription. The CMC program is particularly concerned with appropriate utilization of opioids and benzodiazepines. UnitedHealthcare Community Plan will work with the state in these efforts and adhere to the State's Opioid prior authorization criteria.

Prior authorization procedures and coordination of benefits

UnitedHealthcare Community Plan may not refuse to pre-authorize a service because the member has other insurance. Even if the service is covered by the primary payer, you must follow our prior authorization rules. Prior authorization is not a guarantee of payment. Except for prenatal care and Healthy Kids/EPSDT screening services, you are required to bill other insurers first. For these services, we will pay you and then seek payment from the other insurer.

Timeliness of decisions and notifications to care providers and members

UnitedHealthcare Community Plan makes prior authorization decisions and notifies you and applicable members in a timely manner, unless otherwise required by the Maryland Department of Health. UnitedHealthcare Community Plan adheres to the following decision/notification time standards:

- **Standard authorizations** — within 2 business days of receipt of necessary clinical information, but not later than 14 calendar days of the date of the initial

request
- **Expedited authorizations** — no later than 72 hours after receipt of the request if it is determined the standard time frame could jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function

UnitedHealthcare Community Plan sends a denial notice to care providers and members within a 24-hour time frame for standard and urgent requests.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:
- Patient name and ID number
- Ordering health care professional name and TIN/NPI
- Rendering health care professional and TIN/NPI
- ICD clinical modifications (CM)
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable
- Service setting
- Facility name and TIN/NPI, when applicable

For behavioral health and substance use disorder authorizations, please contact **Optum Maryland.**

If you have questions, go to Maryland's prior authorization page: **UHCprovider. com/MDcommunityplan** > Prior Authorization and Notification Resources.

Services not requiring prior authorization

We encourage out-of-network physicians, facilities and other health care providers to request prior authorization for all nonemergent or urgent procedures and services.

We require prior authorization for some elective services. You must get any needed prior authorization. However, the facility must verify that coverage approval is on file before performing a service. We may deny payment for services rendered without prior authorization. We base final decisions about coverage and payment on member eligibility, the member's benefits, your Agreement and applicable state law.

You may find information on services not requiring prior authorization by visiting UHCprovider.com/MDcommunityplan > **Prior Authorization and Notification** > Current Prior Authorization Plan Requirements.

Utilization review

UnitedHealthcare Community Plan staff performs concurrent review on inpatient stays in acute, rehabilitation and skilled nursing facilities, as well as prior authorization reviews of selected services and pharmaceuticals.

A listing of services requiring prior authorization is posted **UHCprovider.com/MDcommunityplan**. The Advance Notification/Prior Authorization List is provided online and is subject to change. You are informed of changes to this list through the *Medical Policy Update Bulletin* posted on the Bulletins page of the **UHCprovider.com/MDcommunityplan** website. A PCP or specialist can telephone or submit an online prior authorization request to UnitedHealthcare Community Plan. A care provider of the same or similar specialty as the requesting care provider (or pharmacist) reviews all cases in which the care (or prescription medication) does not appear to meet criteria or guidelines adopted by UnitedHealthcare Community Plan Medical Policy Committee.

Decisions regarding coverage are based on the appropriateness of care, service and existence of coverage. Practitioners or other individuals are not specifically rewarded for issuing denials of coverage or service. There are no financial incentives for Utilization Management (UM) decision-makers. We do not encourage decisions that result in underutilization nor are incentives used to encourage barriers to care and service.

The treating care provider has the right to request a peer-to-peer discussion with the reviewing care provider and to request a copy of the criteria used in a review

that results in a denial. Peer-to-peer discussions can be arranged by calling **1-410-540-5965**.

Members and care providers also have the right to appeal denial decisions. The denial letter contains directions as to how to file an appeal. Appeals are reviewed by a care provider who was not involved in the initial denial decision and who is of the same or similar specialty as the requesting care provider. For more information about appeals, see the Appeals section.

Information regarding how to request a peer-to-peer review and an appeal of the decision is included in the denial letter.

You must obtain necessary prior authorization and bill the appropriate entity when a recipient is covered by Medical Assistance. Do not bill the recipient. The only exceptions are situations where a recipient knowingly chooses to be served by a care provider without the necessary prior authorization or referral or requests an uncovered service. In such situations, the care provider must obtain a form, signed by the recipient or legal guardian, clearly stating that the recipient is on Medical Assistance and is knowingly choosing to be seen, even though EVS and/ or their assigned MCO tells them it is an unauthorized procedure/visit and not covered under the Medical Assistance Program.

> For policies and protocols, go to UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > **For Community Plans**.

UM appeals

UM appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. They do not include benefit appeals, which are appeals for non-covered services. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare

Community Plan UM decision may file a UM appeal. See Appeals in **Chapter 12** for more details.

After-hours and emergency care

Members are not required to contact their PCP in emergent/urgent situations. The emergency room staff will triage the member to determine whether an emergency exists. However, the PCP must provide telephone coverage 24 hours a day, 7 days a week for all UnitedHealthcare Community Plan members.

If after triaging the patient, a member does have a nonemergency condition, that individual should be referred back to their PCP.

UnitedHealthcare Community Plan provides a NurseLine service. NurseLine provides 24 hour a day, 365 days a year nurse advice and triage services for our members. Every call is answered by a registered nurse that works with each member to balance the right care, right care provider, right medication, and right lifestyle for their individual needs. When an urgent need exists, the RN will use clinically approved protocols to triage the member and recommend a path of care most appropriate for their symptoms. NurseLine can be reached at **1-877-440-0251**.

Inpatient concurrent review: clinical information

Admission notification must be received within 24 hours after actual weekday admission. For weekend and holiday admissions, notification must be received by 5 p.m. local time on the next business day. Admission notification by the facility is required even if advance notification was supplied by the physician and a pre-service coverage approval is on file.

Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent upon the member's benefit plan, the facility's eligibility for payment, claim processing requirements, and the facility's participation agreement with us.

Admission notifications must contain the following details regarding the admission:

- Member name, health care ID number, and date of birth

- Facility name and TIN or NPI
- Admitting/attending physician name and TIN or NPI
- Description for admitting diagnosis or ICD-10-CM diagnosis code
- Actual admission date

Inpatient admissions and concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation and skilled nursing facilities. We perform a record review or phone review for each stay using MCG, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

UnitedHealthcare Community Plan denies payment for days that do not have a documented need for acute care services. Failure to document results in payment denial to the facility and you.

Concurrent review details

Concurrent review is notification within 24 hours or 1 business day of admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or record review.

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning including primary and secondary diagnosis, clinical information, care plan, admission order, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

Your cooperation is required with all UnitedHealthcare

Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone. You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director.

UnitedHealthcare Community Plan uses MCG (formally Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

Medical necessity criteria

A "medically necessary" service or benefit must be:
- Directly related to diagnostic, preventive, curative, palliative, habilitative or ameliorative treatment of an illness, injury, disability, or health condition
- Consistent with current accepted standards of good medical practice
- The most cost-effective service that can be provided without sacrificing effectiveness or access to care
- Not primarily for the convenience of the member, the member's family or the care provider

Determination process

Benefit coverage for health services is determined by the member specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description and applicable laws.

Clinical practice guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. We adopt and approve clinical guidelines as prescribed by our Medical Technology Assessment Committee (MTAC).

The National Quality Management Oversight Committee reviews the guidelines at least every 2 years or when a new or revised guideline is brought forth.

Clinical Practice Guidelines (CPG) are available through UHCprovider.com/MDcommunityplan > **Policies and Clinical Guidelines**.

Medical and drug policies and coverage determination guidelines

Find medical policies and coverage determination guidelines at UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > **Medical and Drug Policies and Coverage Determination Guidelines for Community Plan**.

Referral guidelines

You must coordinate member referrals for medically necessary services beyond the scope of your practice. Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

We require prior authorization of all out-of-network referrals with the exception of state required self-referral services. The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the medical director for review and determination. Out-of-network referrals are approved for, but not limited to, the following:

- Continuity of care issues
- Necessary services are not available within network

UnitedHealthcare Community Plan monitors out-of-network referrals on an individual basis. Care provider or geographical location trends are reported to Network Management to assess root causes for action planning.

Specialty referrals

- We maintain a complete network of adult and pediatric care providers adequate to deliver the full scope of benefits as required by COMAR 10.67.05 and 10.67.06.
- If a specialty care provider cannot be identified, contact us at **1-877-842-3210** or the Provider Hotline at **1-800-766-8692** for assistance.

Referral authorization process basic guidelines

Most specialist services require a referral from the member's PCP. Referrals should be submitted by the PCP and reviewed by the specialist online. PCPs must submit referrals through one of the following methods before the specialist visit:

- **Online**: Go to UHCprovider.com > **Sign In**
- **Fax**: 1-888-624-2748
- **Mail**:

  P.O. Box 31365
  Salt Lake City, UT 84131-1362

Please refer to the Referral Process Protocol which can be located at UHCprovider.com/MDcommunityplan > **Maryland Specialty Referral Requirements**.

1. The referral must be:
   a. Issued (electronic or paper) referrals to a network care provider or health care professional
   b. Signed and dated by the member's PCP. Electronic referrals do not require signatures.
2. The referral is valid only:
   a. When it is signed and dated on or prior to the service date (paper referrals)
   b. When it is created and submitted on or prior to the service date (electronic referrals)
   c. For a maximum of 6 months from the date it is signed or electronically filed
3. We do not accept retroactive referrals more than 5 days old
4. The PCP should provide members with the referral number before an appointment is made to see a specialist. Members may present the referral form or the electronic referral number to the specialist at the time of the visit, or the PCP's office can mail the written paper referral.
5. **Exceptions to the referral rules –** There are exceptions to the general referral rules for specialty services. Some referrals are able to be issued for more than 12 visits. These exceptions are as follows:
   a. **Laboratory services –** No referral is required. However, based on the laboratory policy, please refer UnitedHealthcare Community Plan members only to the outpatient laboratory service providers that appear on the most current list of participating laboratories at **UHCprovider.com**. Please review this list carefully, and use it for all member laboratory referrals.
   b. **Eye exam –** Referrals are not required for services performed by an optometrist or ophthalmologist.

c. **Post-operative care –** Referrals are not required for services related to a surgical procedure during the postoperative period included in the global fee if performed by the same care provider practice. The PCP must write a new referral if the customer needs to be seen by the same care provider for a new issue or for a new care provider for services related to the surgical procedure.

d. **Radiology services –** A referral is not needed for routine radiology services. However, per the updated policy in specific counties, claims for certain outpatient radiology services performed in a Maryland Health Services Cost Review Commission (HSCRC) rate-regulated facility are no longer reimbursed. Refer members who need procedures for current procedural terminology (CPT) code 70000-79999 to freestanding facilities when clinically appropriate and where access to these facilities is readily available for our members. Outpatient radiology services, if required in conjunction with ER visits and/or outpatient observation confinement, are excluded. The most up-to-date list of contracted facilities can be found by visiting **UHCprovider.com**.

6. **Self-Referral Services:** Members may continue to follow self-referral guidelines for the following services:

a. Emergency services

b. Family planning services

c. Pregnancy-related services, under certain conditions, and freestanding birth centers in Maryland or a neighboring state

d. Initial medical examination for children in state custody by an EPSDT certified provider

e. Initial medical examination of a newborn in a hospital by an on-call physician when the service was not provided prior to discharge from the hospital

f. Services performed by school-based health centers

g. Certain specialists for children

h. One annual DES visit for any member diagnosed with HIV/AIDS

i. Renal dialysis services in a Medicare-certified facility

Reimbursement

Care provider reimbursement

Payment to care providers is in accordance with your provider contract with UnitedHealthcare Community Plan or with their management groups that contract on your behalf with UnitedHealthcare Community Plan. In accordance with the Maryland Annotated Code, Health General Article 15-1005, we must mail or transmit payment to our providers eligible for reimbursement for covered services within 30 days after receipt of a clean claim. If additional information is necessary, we shall reimburse you for covered services within 30 days after receipt of all reasonable and necessary documentation. We shall pay interest on the amount of the clean claim that remains unpaid 30 days after the claim is filed.

Reimbursement for Maryland hospitals and other applicable care provider sites will be in accordance with Health Services Cost Review Commission (HSCRC) rates. UnitedHealthcare Community Plan is not responsible for payment of any remaining days of a hospital admission that began prior to a Medicaid participant's enrollment in our MCO. However, we are responsible for reimbursement to care providers for professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

Please refer to **UHCprovider.com** for additional information.

UnitedHealthcare Community Plan authorization helps ensure reimbursement for all covered services. You should:

- Determine if the member is eligible on the date of service by using the Provider Portal on **UHCprovider.com**, contacting UnitedHealthcare Community Plan's Provider Services Department, or the EVS

- Submit documentation needed to support the medical necessity of the requested procedure

- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized

- Determine if the member has other insurance that should be billed first

UnitedHealthcare Community Plan will not reimburse:

- Services UnitedHealthcare Community Plan decides are not medically necessary
- Noncovered services
- Services provided to members not enrolled on the date(s) of service
- Services not in keeping with reimbursement policy

Second opinions

If a member requests a second opinion, UnitedHealthcare Community Plan will provide for a second opinion from a qualified health care professional within our network. If necessary, we will arrange for the member to obtain one outside of our network.

Scheduling the appointment for the second opinion should follow the access standards established by the MDH. These access standards are defined in Chapter 2. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Care providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward his or her report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating care provider. The participating care provider should contact UnitedHealthcare Community Plan at **1-877-842-3210**.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PCP before receiving treatment

Period of prior authorization

Prior authorization numbers are valid for the dates of service authorized. The member must be eligible for Medicaid and enrolled in UnitedHealthcare Community Plan on each date of service. For information about how to verify member eligibility please contact Provider Services at **1-877-842-3210** Monday through Friday from 8 a.m.–6 p.m.

Services requiring prior authorization

For a list of services that require prior authorization, go to UHCprovider.com/MDcommunityplan > **Prior Authorization and Notification**.

The Advance Notification/Prior Authorization List is provided online and is subject to change. You are informed of changes to this List through the Medical Policy Update Bulletin posted on the Bulletins page of **UHCprovider.com**.

A PCP or specialist can call or submit an online prior authorization request to UnitedHealthcare Community Plan.

Emergency or urgent facility admission – Prior authorization is not required for emergency or urgent care. Out-of-network physicians, facilities and other health care providers must request prior authorization for all procedures and services, excluding emergent or urgent care.

Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/Prevention

Key contacts

Topic	Link	Phone Number
EPSDT	mmcp.health.maryland.gov > Children's Health > **Early Periodic Screening Diagnosis and Treatment**	1-877-463-3464
Vaccines for Children	phpa.health.maryland.gov/Pages/home.aspx > A-Z Index > **Vaccines for Children**	1-800-232-4636

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Early Periodic Screening Diagnosis and Treatment (EPSDT) requirements

UnitedHealthcare Community Plan will assign children and adolescents younger than age 21 to a PCP who is certified by the EPSDT/Healthy Kids Program. If member's parent, guardian, or caretaker, as appropriate, specifically requests assignment to a PCP who is not EPSDT-certified, the nonEPSDT care provider is responsible for ensuring that the child receives well childcare according to the EPSDT schedule. If you provide primary care services to individuals under age 21 and are not EPSDT certified call **1-410-767-1836**. For more information about the HealthyKids/EPSDT Program and Expanded EPSDT services for children under age 21, go to **mmcp.health.maryland.gov**.

You must follow the Maryland Healthy Kids/EPSDT Program Periodicity Schedule and all associated rules to fulfill the requirements under Title XIX of the Social Security Act for providing children younger than 21 with EPSDT services. The Program requires you to:

- Notify members of their due dates for wellness services and immunizations
- Schedule and provide preventive health services according to the state's EPSDT Periodicity Schedule and Screening Manual

- Refer infants and children under age 5 and pregnant teens to the Supplemental Nutritional Program for Women Infants and Children (WIC). Provide the WIC Program with member information about hematocrits and nutrition status to assist in determining a member's eligibility for WIC.
- Participate in the Vaccines For Children (VFC) Program. Many of the routine childhood immunizations are furnished under the VFC Program. The VFC Program provides free vaccines for health care providers who participate in the VFC Program. We will pay for new vaccines that are not yet available through the VFC Program.
- Schedule appointments at an appropriate time interval for any member who has an identified need for follow-up treatment as the result of a diagnosed condition

Members under age 21 are eligible for a wider range of services under EPSDT than adults. PCPs are responsible for understanding these expanded services. See **MCO Benefits and Services Overview – Chapter 3**. PCPs must make appropriate referrals for services that prevent, treat, or ameliorate physical, mental or developmental problems or conditions.

You shall refer children for specialty care as appropriate. Referrals must be made when a child:

- Is identified as being at risk of a developmental delay by the developmental screen required by EPSDT

- Has a 25% or more delay in any developmental area as measured by appropriate diagnostic instruments and procedures
- Manifests atypical development or behavior
- Has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay

A child thought to have been physically, mentally, or sexually abused must be referred to a specialist who is able to make that determination.

EPSDT outreach and referral to LHD

For each scheduled Healthy Kids appointment, written notice of the appointment date and time must be sent by mail to the child's parent, guardian, or caretaker, and attempts must be made to notify the child's parent, guardian, or caretaker of the appointment date and time by telephone.

- For children from birth through 2 years of age who miss EPSDT appointments and for children under age 21 who are determined to have parents, care givers or guardians who are difficult to reach, or repeatedly fail to comply with a regimen of treatment for the child, you should follow the procedures below to bring the child into care
- Document outreach efforts in the medical record. These efforts should include attempts to notify the member by mail, by telephone, and through face-to-face contact.

Schedule a second appointment within 30 days of the first missed appointment.

Within 10 days of the child missing the second consecutive appointment, request assistance in locating and contacting the child's parent, guardian or caretaker by calling UnitedHealthcare Community Plan at **1-877-842-3210**. You may concurrently make a written referral to the LHD ACCU by completing the Local Health Services Request form. See **Attachment #4**. Continue to work collaboratively with UnitedHealthcare Community Plan and the ACCU until the child is in care and up to date with the EPSDT periodicity schedule or receives appropriate follow-up care.

Support and outreach services are also available to members that have **impaired cognitive ability or psychosocial problems such as homelessness** or

other conditions likely to cause them to have difficulty understanding the importance of care instructions or difficulty navigating the health care system. You must notify UnitedHealthcare Community Plan if these members miss 3 consecutive appointments or repeatedly does not follow their treatment plan. We will attempt to outreach the member and may make a referral to the ACCU to help locate the member and get them into care.

Chapter 6: Value-Added Services

Key contacts

Topic	Link	Phone Number
Provider Services	**UHCprovider.com**	1-877-842-3210
Healthy First Steps Rewards	**uhchealthyfirststeps.com**	1-800-599-5985
Value-Added Services	**UHCCommunityPlan.com/MD** > View plan details	1-877-842-3210

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Medicaid benefits covered by the state — not covered by UnitedHealthcare Community Plan of Maryland

- The state covers dental services for all members who receive full Medicaid benefits. The Maryland Healthy Smiles Dental Program is responsible for routine preventive services, restorative service and orthodontia. Orthodontia must meet certain criteria and requires prior authorization by Skygen USA, the state's ASO. Skygen USA assigns members to a dentist and issues a dental Healthy Smiles ID card. However, the member may go to any Healthy Smiles participating dentist. If you have questions about dental benefits call **1-855-934-9812**.
- Outpatient rehabilitative services for children younger than age 21
- Specialty mental health and substance use disorders covered by the Specialty Behavioral Health System
- Intermediate care facilities for individuals with intellectual disabilities or persons with developmental disabilities
- Personal care services
- Medical day care services, for adults and children
- Abortions (covered under limited circumstances – no federal funds are used. Claims are paid through the Maryland Medical Care Program). If a member was determined eligible for Medicaid based on their pregnancy, they are not eligible for abortion services.
- Emergency transportation (billed by local EMS)
- Nonemergency transportation services provided through grants to local governments
- Services provided to members participating in the state's Health Home Program and certain high-cost, low-volume drugs

Benefit limitations

UnitedHealthcare Community Plan of Maryland does not cover these services except where noted, and the state does not cover these services.

- Services performed before the effective date of the member's enrollment in the MCO are not covered by the MCO but may be covered by Medicaid fee-for-service if the member was enrolled in Medicaid
- Services that are not medically necessary
- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state)
- Services that are beyond the scope of practice of the health care practitioner performing the service
- Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when a member is participating in an authorized clinical trial
- Cosmetic surgery to improve appearance or

related services, but not including surgery and related services to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental abnormalities

- While enrolled in an MCO, services, except for emergency services, are not covered when the member is outside the state of Maryland unless the care provider is part of UnitedHealthcare Community Plan of Maryland's network. Services may be covered when provided by an MCO network care provider who has obtained the proper referral or prior authorization if required. If a Medicaid beneficiary is not in an MCO on the date of service, Medicaid fee-for service may cover the service if it is a covered benefit and if the out-of-state care provider is enrolled in Maryland Medicaid;
- Services provided outside the United States
- Immunizations for travel outside the United States
- Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis
- Private hospital room is not covered unless medically necessary or no other room is available
- Autopsies
- Private duty nursing services for adults 21 years old and older
- Orthodontia is not covered by the MCO but may be covered by Healthy Smiles when the member is younger than 21 and scores at least 15 points on the Handicapping Labio-lingual Deviations Index No. 4 and the condition causes dysfunction
- Ovulation stimulants, in vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar
- Reversal of voluntary sterilization procedures
- Medications for the treatment of sexual dysfunction
- MCOs are not permitted to cover abortions. We are required to assist members in locating these services and we are responsible for related services (sonograms, lab work, but the abortion procedure, when conditions are met, must be billed to Medicaid fee-for service.
- Nonlegend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the member is under 12 years old and non-legend drugs other than insulin and enteric-coated aspirin for arthritis

- Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy
- Diet and exercise programs for weight loss except when medically necessary
- Lifestyle improvements (physical fitness programs and nutrition counseling, unless specified)
- MCOs do not cover emergency transportation services and are not required to cover nonemergency transportation services (NEMT). UnitedHealthcare Community Plan of Maryland will assist members to access non-emergency transportation through the local health department. We will provide some transportation if necessary to fill any gaps that may temporarily occur in our network. Members may contact Member Services at **1-800-318-8821 (TTY 711)**, Monday-Friday 8 a.m.-7 p.m. for assistance.

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services at **1-877-842-3210** unless otherwise noted.

Optional services covered by UnitedHealthcare Community Plan of Maryland

In addition to those services previously noted, UnitedHealthcare Community Plan of Maryland currently provides the following optional services to our members. These services are not taken into account when setting our capitation rate. MCO optional services may change each calendar year. We may not discontinue or reduce these services without providing advance notification to the state.

Aunt Bertha

This web-based social care network connects members to free or reduced cost need-based social services. This platform helps users:

- Search for programs
- Make referrals for members
- Track referral outcomes
- View reports of search, referral and community

organization activity

Chronic condition management

We use educational materials and newsletters to remind members to follow positive health actions such as recommended immunization schedules, routine wellness visits and EPSDT screenings for children 0-21 years. For those members with chronic conditions, we provide specific information, including recommended routine appointment frequency, necessary testing, monitoring, and self-care through our disease management (DM) program. All materials are based upon evidence-based guidelines or standards. All printed materials are written at a fifth grade reading level. They are available in English as well as other languages. The materials are designed to support members as they begin to take responsibility for their health. They provide information necessary to successfully manage their condition and live a healthy lifestyle.

Members at highest risk with conditions such as asthma, CHF, diabetes, COPD and CAD receive more intense health coaching when in case management. Resources and tools are available to support members and caregivers with conditions common to children with special health care needs and help them manage their illness.

Identification – The health plan uses claims data (e.g., hospital admissions, ER visits, and pharmacy claims) to identify members with gaps in care and/or chronic conditions.

Referral – PCPs may make referrals to support practice-based interventions by contacting the Special Needs Unit at **1-800-460-5689**.

Dental care for pregnant members

Dental services for pregnant members are provided by the Maryland Healthy Smiles Dental Program, administered by Skygen USA. Contact them at **1-855-934-9812** if you have questions about dental benefits.

Healthy First Steps® Rewards

Healthy First Steps® (HFS) Rewards is a specialized case management program designed to provide assistance to all pregnant members, those experiencing an uncomplicated pregnancy, as well as additional medical, behavioral, and social risks. The goal is improving birth outcomes and lowering NICU admissions by managing prenatal and postpartum care needs of pregnant members. Care management staff are board-certified in maternal and neonatal medicine.

Members self-enroll on a smartphone or computer. They can go to **uhchealthyfirststeps.com** and click on "Register" or call **1-800-599-5985**.

How it works

Care providers and UnitedHealthcare Community Plan reach out to members to enroll them.

Members enter information about their pregnancy and upcoming appointments online. Members get reminders of upcoming appointments and record completed visits.

How you can help

- Identify UnitedHealthcare Community Plan members during prenatal visits
- Share the information with the member to talk about the program
- Encourage the member to enroll at **uhchealthyfirststeps.com**

Mobile apps

Apps are available at no charge to our members. They include **Health4Me**, which enables users to review health benefits, access claims information and locate in-network care providers.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their

PCP. Our nurses also help educate members about staying healthy. Call **1-877-440-0251** to reach a nurse.

On My Way

This online program helps young adults who are either transitioning from foster care or from their parents'/guardians' home to independent living. OMW teaches skills on budgeting, housing, job training and attending college.

To learn more about the UnitedHealthcare Community Plan OMW program, go to **uhcOMW.com**. If you have questions, call the Special Needs Unit at **1-800-460-5689**.

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	**providerexpress.com**	1-800-888-2998
Provider Services	**UHCprovider.com**	1-877-842-3210

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Primary behavioral health services

We cover primary behavioral health services, including assessment, clinical evaluation and referral for additional services. The PCP may elect to treat the member, if the treatment, including visits for buprenorphine treatment, falls within the scope of the PCP's practice, training, and expertise. Referrals for behavioral health services can be made by calling the state's ASO at **1-800-888-1965**, Monday–Friday: 8 a.m. to 6 p.m.

Maryland opioid prescribing guidance and policies

The following policies apply to both Medicaid Fee-for-Service and all 9 Managed Care Organizations (MCO):

Policy

Prior authorization is required for long-acting opioids, fentanyl products, methadone for pain, and any opioid prescription that results in a patient exceeding 90 morphine milliequivalents (MME) per day. A standard 30-day quantity limit for all opioids is set at or below 90 MME per day. The CDC advises, "clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 MME/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day." In order to prescribe a long acting opioid, fentanyl products, methadone for pain and opioids above 90 MME daily, a prior authorization must be obtained every 6 months.

The prior authorization requires the following items: an attestation that the care provider has reviewed Controlled Dangerous Substance (CDS) prescriptions in the Prescription Drug Monitoring Program (PDMP); an attestation of a Patient-Provider agreement; attestation of screening patient with random urine drug screens before and during treatment; and attestation that a naloxone prescription was given/offered to the patient/patient's household member. Patients with cancer, sickle cell anemia or in hospice are excluded from the prior authorization process but they should also be kept on the lowest effective dose of opioids for the shortest required duration to minimize risk of harm. HealthChoice MCOs may choose to implement additional requirements or limitations beyond the state's policy.

Naloxone should be prescribed to patients that meet certain risk factors. Both the CDC and Centers for Medicaid and Medicare Services have emphasized that clinicians should incorporate strategies to mitigate the risk of overdose when prescribing opioids. We encourage care providers to prescribe naloxone — an opioid antagonist used to reverse opioid overdose — if any of the following risk factors are present: history of substance use disorder; high dose or cumulative prescriptions that result in over 50 MME; prescriptions for both opioids and benzodiazepine or non-benzodiazepine sedative hypnotics; or other factors, such as drug-using friends/family.

Guidance

Non-opioids are considered first line treatment for chronic pain. The CDC recommends expanding first line treatment options to non-opioid therapies for pain. In order to address this recommendation, the following evidence-based alternatives are available within the Medicaid program: NSAIDs, duloxetine for chronic pain; diclofenac topical; and certain first line non-pharmacological treatment options (e.g., physical therapy). Some MCOs have optional expanded coverage that is outlined in the attached document.

Care providers should screen for substance use disorder. Before writing for an opiate or any controlled substance, care providers should use a standardized tool to screen for substance use. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an example of a screening tool. Caution should be used in prescribing opioids for any patients who are identified as having any type of or history of substance use disorder. Refer any patient identified as having a substance use disorder to a substance use treatment program.

SBIRT is an evidenced-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and drugs. The practice has proved successful in hospitals, specialty medical practices, emergency departments and workplace wellness programs. SBIRT can be easily used in primary care settings and enables care providers to systematically screen and assist people who may not be seeking help for a substance use problem but whose drinking or drug use may cause or complicate their ability to successfully handle health, work or family issues. The provision of SBIRT is a billable service under Medicaid. Information on billing may be accessed here: mmcp.health.maryland.gov.

Patients identified with substance use disorder should be referred to substance use treatment. Maryland Medicaid administers specialty behavioral health services through a single Administrative Services Organization — Optum Maryland. If you need assistance in locating a substance use treatment provider, Optum Maryland may be reached at 800-888-1965. If you are considering a referral to behavioral health treatment for one of your patients, additional resources may be accessed at maryland.optum.com.

Care providers should use the PMDP every time they write a prescription for CDS. Administered by MDH, the PDMP gives health care providers online access to their patients' complete CDS prescription profile. Practitioners can access prescription information collected by the PDMP at no cost through the CRISP health information exchange, an electronic health information network connecting all acute care hospitals in Maryland and other health care facilities. Care providers who register with CRISP get access to a powerful "virtual health record" that includes patient hospital admission, discharge and transfer records, laboratory and radiology reports and clinical documents, as well as PDMP data.

> For more information about the PDMP, visit the MDH website: **health.maryland.gov/ pdmp/pages/home.aspx**. If you are not already a registered CRISP user you can register for free at **crisphealth.force.com**. PDMP usage is highly encouraged for all CDS prescribers and will become mandatory to check patients CDS prescriptions if prescribing CDS at least every 90 days (by law) in July 1, 2018.

If a MCO is implementing any additional policy changes related to opioid prescribing, the MCO will notify care providers and beneficiaries.

[1] Instructions on calculating MME is available at: **cdc.gov**

[2] CDC guidance: **cdc.gov**; and CMS guidance: **medicaid.gov**)

[3] A description of these substance use screening tools may be accessed at: **integration.samhsa.gov/clinical-practice/screening-tools**

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction.

Brief summary of framework

- **Prevention** – Prevent opioid-use disorders (OUD) before they occur through pharmacy management, care provider practices, and education
- **Treatment** – Access and reduce barriers to evidence-based and integrated treatment
- **Recovery** – Support case management and referral to person-centered recovery resources
- **Harm reduction** – Access to naloxone and facilitating safe use, storage, and disposal of opioids
- **Strategic community relationships and approaches** – Tailor solutions to local needs
- **Enhanced solutions for pregnant parent and**

child – Prevent neonatal abstinence syndrome and supporting moms in recovery

- **Enhanced data infrastructure and analytics** – Identify needs early and measure progress

Increasing education and awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on our care provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, "The Role of the Health Care Team in Solving the Opioid Epidemic," and "The Fight Against the Prescription Opioid Abuse Epidemic." While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at UHCprovider.com > Resources > **Drug Lists and Pharmacy**. Click "Opioid Programs and Resources - Community Plan" to find a list of tools and education.

Prescribing opioids

Go to our **Drug Lists and Pharmacy page** to learn more about which opioids require prior authorization and if there are prescription limits.

Corrective managed care/pharmacy lock-in

Members who have a pattern of misusing prescription or OTC drugs may be required to use only one pharmacy to fill their prescriptions. This is called a "lock-in." If this happens, UnitedHealthcare Community Plan sends the member a letter and asks that they choose an in-network pharmacy designated for the lock-in. If the member does not select a pharmacy one is selected for them. We help ensure members can get the medicines they need, in case of an emergency. A 72-hour emergency supply at other pharmacies may be allowed.

The clinical pharmacy team notifies the members selected for inclusion in the restriction program by letter, providing member a 20-day notice, prior to the restriction beginning, to allow members time to submit additional information, appeal and select a pharmacy. Members should be directed to call Member Services at the number on the back of their ID card to file an appeal.

Coordination of care

When a member is receiving services from more than one professional, the care providers must coordinate so they deliver comprehensive, safe and effective care. This is especially true when the member:

- Is prescribed medication
- Has coexisting medical/psychiatric symptoms, or
- Has been hospitalized for a medical or psychiatric condition

Please talk to your patients about the benefits of sharing essential clinical information.

Key contacts

Topic	Link	Phone Number
Member Services	**UHCCommunityPlan.com/MD**	1-800-318-8821
Member Handbook	**UHCCommunityPlan.com/MD** > Community Plan > Member benefits	

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Our Member Handbook has a section on member rights and responsibilities. In it, we ask that members treat you with respect and courtesy.

Member rights and responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: **UHCCommunityPlan.com**.

Member rights

Members of UnitedHealthcare Community Plan have the right to:
- Give and be treated with respect, dignity and privacy
- Receive health care and services that are culturally competent and free from discrimination
- Receive information, including information on treatment options and alternatives, regardless of cost or benefit coverage, in a manner that is understandable
- Participate in decisions regarding their health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of their medical records and request that they be amended or corrected as allowed
- Request copies of all documents, records, and

other information free of charge, that was used in an adverse benefit determination
- Exercise their rights and know that the exercise of those rights will not adversely affect the way that you, UnitedHealthcare Community Plan or the Department of Health will treat them
- File appeals and grievances with UnitedHealthcare Community Plan
- File appeals, grievances and State Fair Hearings with the state
- Request that ongoing benefits be continued during an appeal or State Fair Hearing; however, they may have to pay for continued benefits if the decision is upheld in the appeal or hearing
- Receive a second opinion from another doctor within the UnitedHealthcare Community Plan care provider network, or by an out-of-network care provider if the care provider is not available within the plan, if the member does not agree with their doctor's opinion about the services that they need. They may call Member Services at **1-800-318-8821 (TTY 711)**, Monday-Friday, 8 a.m.-7 p.m. for help with this
- Receive other information about how UnitedHealthcare Community plan is managed including the structure and operation of the plan as well as physician incentive plans. They may request this information by calling Member Services at **1-800-318-8821 (TTY 711)**, Monday-Friday, 8 a.m.-7 p.m.
- Receive information about the plan, its services, its practitioners and care providers and member rights and responsibilities
- Members may also make recommendations for

changes to the UnitedHealthcare Community Plan's member rights and responsibilities policy

Member responsibilities

As a UnitedHealthcare Community Plan member, they should:

- Inform you and UnitedHealthcare Community Plan if they have any other health insurance coverage
- Treat you and your staff, HealthChoice staff and UnitedHealthcare Community Plan staff with respect and dignity
- Arrive to appointments on time and notify you as soon as possible if they need to cancel an appointment
- Show their membership card when they check in for every appointment. They may never allow anyone else to use their Medicaid or UnitedHealthcare Community Plan card. Members may report lost or stolen ID cards to Member Services at **1-800-318-8821 (TTY 711)**, Monday-Friday, 8 a.m.-7 p.m.
- Contact UnitedHealthcare Community Plan if they have a problem or a complaint
- Work with their PCP to create and follow a plan of care that both parties can agree on
- Ask questions about their care and let you know if there is something that they do not understand
- Update the state if there has been a change in their status
- Provide you and UnitedHealthcare Community Plan with accurate health information in order to provide proper care
- Use the emergency department for emergencies only
- Tell their PCP as soon as possible after they receive emergency care
- Inform their caregivers about any changes to their advance directive

HIPAA and member privacy rights

The following information comes from the Member Handbook at **UHCCommunityPlan.com** under the Member Information tab.

The Health Insurance Portability and Accountability Act (HIPAA) requires MCOs and care providers to report their privacy practices to their members. The Notice of Privacy Practices informs members of their rights to privacy as well as the access and disclosure of their protected health information (PHI). Examples of PHI include medical records, medical claims/billing, and health plan records. If you feel that your privacy rights have been violated, you can file a complaint with your provider, MCO, or the U.S. Department of Health and Human Services.

To file a complaint, see contact information below:

- Care provider: call your care provider's office
- UnitedHealthcare Community Plan: call Member Services at **1-800-318-8821, TTY 711**, Monday through Friday 8 a.m.-7 p.m. ET
- U.S. Department of Health and Human Services
  - **Online** – **ocrportal.hhs.gov**
  - **Email** – **OCRComplaint@hhs.gov**
  - **In writing** –
    Centralized Case Management Operations U.S. Department of Health and Human Services
    200 Independence Avenue SW Room 509F, HHH Bldg.
    Washington, D.C. 20201

Privacy regulations

HIPAA privacy regulations offer full federal protection to protect member health care information. These regulations control the internal and external uses and disclosures of such data. They also create member rights.

Access to PHI

Members may access their medical records or billing information either through you or us. If their information is electronic, they may ask that you or we send a copy in an electronic format. They may also ask that a copy of their information be provided to a third party.

Amendment of PHI

Our members have the right to ask that you or we change information they believe to be inaccurate or incomplete. The member request must be in writing and explain why they want the change. You or we must act on the request within 60 days, or may extend another 30 days with written notice. If denying the request, provide certain information to the member explaining the denial reason and actions the member must take.

Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their PHI, made by you or us, during 6 years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:

- For treatment, payment and health care operations purposes
- To members or pursuant to member's authorization
- To correctional institutions or law enforcement officials
- For which federal law does not require us to give an accounting

Right to request restrictions

Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means. You must accommodate reasonable requests, especially if the member states disclosure could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Anti-gag provisions

Care providers participating with UnitedHealthcare Community Plan will not be restricted from discussing with or communicating to a member, enrollee, subscriber, public official, or other person information that is necessary or appropriate for the delivery of health care services, including:

1. Communications that relate to treatment alternatives including medication treatment options regardless of benefit coverage limitations
2. Communication that is necessary or appropriate to maintain the care provider-patient relationship while the member is under the participating physician's care
3. Communications that relate to a member's or subscriber's right to appeal a coverage determination with which the participating physician, member, enrollee, or subscriber does not agree
4. Opinions and the basis of an opinion about public policy issues

Participating care providers agree that a determination by UnitedHealthcare Community Plan that a particular course of medical treatment is not a covered benefit shall not relieve participating care providers from recommending such care as they deem to be appropriate nor shall such benefit determination be considered to be a medical determination. Participating care providers further agree to inform beneficiaries of their right to appeal a coverage determination pursuant to the applicable grievance procedures and according to law. Care providers contracted with multiple MCOS are prohibited from steering recipients to any one specific MCO.

Looking for something?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Medical records requirements

You are required to keep complete and orderly medical records, in paper or electronic format, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying United Healthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral care providers
Record Organization and Documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records. • Release only to entities as designated consistent with federal requirements • Keep in a secure area accessible only to authorized personnel

Topic	Contact
Procedural Elements	**Medical records are readable*** • Sign and date all entries • Member name/identification number is on each page of the record • Document language or cultural needs • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English • Procedure for monitoring and handling missed appointments is in place • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions*

History	An initial history (for members seen 3 or more times) and physical is performed. It should include:
	• **Medical and surgical history***
	• A family history that includes relevant medical history of parents and/or siblings
	• A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11
	• Current and history of immunizations of children, adolescents and adults
	• Screenings of/for:
	  - Recommended preventive health screenings/tests
	  - Depression
	  - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit
	  - Medicare members for functional status assessment and pain
	  - Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Topic	Contact

Problem Evaluation and Management	Documentation for each visit includes:
	• Appropriate vital signs (Measurement of height, weight and BMI annually)
	  - **Chief complaint***
	  - **Physical assessment***
	  - **Diagnosis***
	  - **Treatment plan***
	• Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines
	• Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)
	• Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets
	• Treatment plans are consistent with evidence-based care and with findings/diagnosis:
	  - Time frame for follow-up visit as appropriate
	  - Appropriate use of referrals/consults, studies, tests
	• X-rays, labs consultation reports are included in the medical record with evidence of care provider review
	• There is evidence of care provider follow-up of abnormal results
	• Unresolved issues from a previous visit are followed up on the subsequent visit
	• There is evidence of coordination with behavioral health care provider
	• Education, including lifestyle counseling, is documented
	• Member input and/or understanding of treatment plan and options is documented
	• Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented

*Critical element

Member copies

A member or their representative is entitled to one free copy of their medical record. Additional copies may be available at the member's cost. Medical records are generally kept for a minimum of 5 years unless federal requirements mandate a longer time frame (i.e., immunization and TB records required for lifetime).

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. We expect you to achieve a passing score of 85% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than 2 visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
  - Biographical data with family history
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution
  - Documentation of education/counseling regarding HIV pre- and post-test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions
- Immunization record
- Tobacco habits, alcohol use and substance abuse (12 years and older)
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits, diagnosis and treatment plans consistent with finding
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other care providers
- Notes regarding the date of return visit or other follow-up
- Consultations, lab, imaging and special studies initialed by PCP to indicate review
- Consultation and abnormal studies including follow-up plans

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9)

Confidentiality and accuracy of member records

You must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies a UnitedHealthcare Community Plan member. Original medical records must be released only in accordance with federal or Maryland laws, court orders or subpoenas.

You must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations. Learn more at **hhs.gov/ocr/privacy**.

Key contacts

Topic	Link	Phone Number
Credentialing	Medical:Network Management Resource Team at **Networkhelp@uhc.com** Chiropractic: **myoptumphysicalhealth.com**	1-877-842-3210
Fraud, Waste and Abuse (Payment Integrity)	**uhc.com/fraud**	1-800-455-4521

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

UnitedHealthcare Community Plan Quality Initiatives

What is the Quality Improvement program?

UnitedHealthcare Community Plan's comprehensive Quality Improvement program falls under the leadership of the CEO and the chief medical officer. A copy of our Quality Improvement program is available upon request.

The program consists of:
- Identifying the scope of care and services given
- Developing clinical guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services given to our members based on the guidelines
- Promoting wellness and preventive health, as well as chronic condition self-management
- Maintaining a network of care providers that meets adequacy standards
- Striving for improvement of member health care and services
- Monitoring and enhance patient safety
- Tracking member and care provider satisfaction and take actions as appropriate

As a participating care provider, you may offer input through representation on our Quality Improvement Committees and your provider services representative/ provider advocate.

Cooperation with quality-improvement activities

You must comply with all quality-improvement activities. These include:
- Providing requested timely medical records
- Cooperating with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participating in quality audits, such as site visits and medical record standards reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email or secure email.
- Completing practitioner appointment access and availability surveys
- Allowing the plan to use your performance data
- Offering Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members)

Quality assurance monitoring plan

The quality assurance monitoring plan for the HealthChoice program is based upon the philosophy that the delivery of health care services, both clinical and administrative, is a process that can be continuously improved. The state of Maryland's quality assurance plan structure and function support efforts to deal efficiently and effectively with any identified quality issue. Daily, and through a systematic audit of MCO operations and health care delivery, the Department identifies both positive and negative trends in service delivery. Quality monitoring and evaluation and education through member and care provider feedback are an integral part of the managed care process and help ensure that cost containment activities do not adversely affect the quality of care provided to members.

The Department's quality assurance monitoring plan is a multifaceted strategy for assuring that the care provided to HealthChoice members is high quality, complies with regulatory requirements, and is rendered in an environment that stresses continuous quality improvement. Components of the Department's quality improvement strategy include: establishing quality assurance standards for MCOs; developing quality assurance monitoring methodologies; and developing, implementing and evaluating quality indicators, outcome measures, and data reporting activities, including:

- Health Service Needs Information form completed by the participant at the time they select an MCO to assure that the MCO is alerted to immediate health needs, e.g., prenatal care service needs
- A complaint process administered by MDH staff
- A complaint process administered by UnitedHealthcare Community Plan
- A systems performance review of each MCO's quality improvement processes and clinical care performed by an External Quality Review Organization (EQRO) selected by the Department. The audit assesses the structure, process, and outcome of each MCO's internal quality assurance program.
- Annual collection, validation and evaluation of the Healthcare Effectiveness Data and Information Set (HEDIS®), a set of standardized performance measures designed by the National Committee for Quality Assurance (NCQA) and audited by an independent entity

- Other performance measures developed and audited by MDH and validated by the EQRO
- An annual member satisfaction survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), developed by NCQA for the Agency for Healthcare Research and Quality
- Monitoring of preventive health, access and quality of care outcome measures based on encounter data
- Development and implementation of an outreach plan
- A review of services to children to determine compliance with federally required EPSDT standards of care
- Production of a Consumer Report Card
- An Annual Technical Report that summarizes all Quality Activities

To report these measures to MDH, UnitedHealthcare Community Plan must perform chart audits throughout the year to collect clinical information on our Members. UnitedHealthcare Community Plan truly appreciates the care provider offices' cooperation when medical records are requested.

In addition to information reported to MDH, UnitedHealthcare Community Plan collects additional quality information. You may need to provide records for standard medical record audits that ensure appropriate record documentation. Our Quality Improvement staff may also request records or written responses if quality issues are raised in association with a member complaint, chart review, or referral from another source.

Care provider satisfaction

Every year, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through:

- Annual care provider satisfaction surveys
- Regular visits
- Town hall meetings

Our chief concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

Survey results are reported to our Quality Management Committee. It compares the results year over year as well as to other UnitedHealthcare Community Plan

plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. We respect our network care providers. We appreciate the collaboration to promote better health, improve health outcomes and lower overall costs to offer our members. You are encouraged to visit the following website to view the guidelines, as they are an important resource to guide clinical decision-making.

UHCprovider.com/cpg

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Maryland statutes and the National Committee of Quality Assurance (NCQA). The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current Drug Enforcement Administration (DEA) certificate
- Current professional liability insurance

We verify information from primary sources regarding licensure, education and training. We also verify board certification and malpractice claims history.

Credentialing and recredentialing process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care provider network. You must go through the credentialing and recredentialing process before you may treat our members.

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral health clinicians (psychologists, clinical social workers, Masters prepared therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting
- Hospitalists employed only by the facility, and/or
- NPs and PAs who practice under a credentialed UnitedHealthcare Community Plan care provider

Health facilities

Facility providers such as hospitals, home health agencies, skilled nursing facilities and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements.

Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and NPI number
- Have a current unrestricted license to operate
- Have been reviewed and approved by an accrediting body
- Have malpractice coverage/liability insurance that meets contract minimums
- Agree to a site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency
- Have no Medicare/Medicaid sanctions

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based on race, ethnic/ national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

The National Credentialing Center (NCC) completes these reviews. Find applications on the Council for Affordable Quality Healthcare (CAQH) website.

Go to **UHCprovider.com/join** to submit a participation request.

For chiropractic credentialing, call **1-800-873-4575** or go to **myoptumhealthphysicalhealth.com**.

Submit the following supporting documents to CAQH after completing the application:

- Curriculum vitae
- Medical license
- DEA certificate
- Malpractice insurance coverage
- IRS W-9 Form

Peer review

Credentialing and contracting with UnitedHealthcare Community Plan

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review.

Re-credentialing

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

Care provider performance data

As part of the recredentialing process, UnitedHealthcare Community Plan looks in its Quality Management database for information about your performance. This includes member complaints and quality of care issues.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the NMRT finds erroneous information, a representative will contact you by phone or in writing. You must submit corrections within 30 days of notification by phone, or in writing to the number or address the NMRT representative provided.

You also have the right to receive the status of your credentialing application, please email us at **networkhelp@uhc.com**. Include your full name, NPI, TIN and brief description of the request. A UnitedHealthcare representative will be in touch with you within 2 business days from when we receive your request.

Confidentiality

All credentialing information collected during the review process is kept confidential. It is only shared with your approval or as required by law with those involved in the credentialing process.

Resolving disputes

Contract concerns

If you have a concern about your Agreement with us, send a letter to:

> **UnitedHealthcare Community Plan Central Escalation Unit**
> P.O. Box 5032
> Kingston, NY 12402-5032

A representative will work to resolve the issue with you. If

you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your Provider Agreement.

If your concern is about a UnitedHealthcare Community Plan procedure, such as the credentialing or Care Coordination process, we will resolve it by following the procedures in that plan. If you are still dissatisfied, please follow the dispute resolution provisions in your Provider Agreement.

If we have a concern about our Agreement with you, we will send you a letter. If the issue can't be resolved this way, please follow the dispute resolution provisions in your Provider Agreement.

If a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the Member Handbook and this manual.

HIPAA compliance — your responsibilities

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. HIPAA impacts what is referred to as covered entities; specifically, care providers, health plans, and health care clearinghouses that transmit health care information electronically. The Health Insurance Portability and Accountability Act (HIPAA) have established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. You are required to adhere to HIPAA regulations. For more information about these standards, please visit **hhs.gov/ocr/hipaa/**. In accordance with HIPAA guidelines, you may not interview members about medical or financial issues within hearing range of other patients.

Transactions and code sets

If you conduct business electronically, submit claims using the standard formats adopted under HIPAA.

Otherwise, submit claims using a clearinghouse.

Unique identifier

HIPAA also requires unique identifiers for employers, health care providers, health plans and individuals for use in standard transactions.

National Provider Identifier

The NPI is your standard unique identifier. It is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While HIPAA only requires you to use the NPI in electronic transactions, many state agencies require it on fee-for-service claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan.

Privacy of individually identifiable health information

The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members' medical information. The regulations protect medical records and other identifiable health information. This includes electronic, paper or spoken data.

They enhance consumers' rights by giving them access to their health information and controlling its inappropriate use. They also improve health care delivery by extending the privacy efforts of states and health systems to a national level.

Security

Covered entities must meet basic security measures:
- Help ensure the confidentiality, integrity and availability of all electronic PHI the covered entity creates,
- Protect against any reasonably anticipated threats,

uses or disclosures of information not permitted or required under the privacy regulations

- Help ensure compliance with the security regulations by the covered entity's staff

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations.

Find additional information on HIPAA regulations at **cms.hhs.gov**.

Ethics and integrity

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, suppliers and government officials and agencies. Making sound decisions as we interact with you, other health care providers, regulators and others is necessary for our continued success and that of our business associates. It's also the right thing to do.

Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required 7 elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the Ethics and Integrity program
- Development and implementation of ethical standards and business conduct policies
- Creating awareness of the standards and policies by educating employees
- Assessing compliance by monitoring and auditing
- Responding to allegations of violations
- Enforcing policies and disciplining confirmed misconduct or serious neglect of duty
- Reporting mechanisms for workers to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health plan has a compliance committee consisting of senior managers from key organizational areas. The committee provides program direction and oversight.

Reporting and auditing

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.

UnitedHealthcare Community Plan's Special Investigations Unit (SIU) is an important part of the Compliance program. The SIU focuses on prevention, detection and investigation of potentially fraudulent and abusive acts committed by care providers and members. This department oversees coordination of anti-fraud activities.

To facilitate the reporting process of questionable incidents involving members or care providers, call our **Fraud and Abuse line** or go to **uhc.com/fraud**.

Please refer to the Fraud, Waste and Abuse section of this manual for additional details about the UnitedHealthcare Community Plan Fraud, Waste and Abuse program.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

If you become the subject of a government inquiry or investigation, or a government agency requests documents relating to your operations (other than a routine request for documentation), you must provide UnitedHealthcare Community Plan with the details. You must also reveal what triggered the inquiry.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the MDH to perform "individual and corporate extrapolation

audits." This may affect all programs supported by dual funds (state and federal funding) as well as state-funded programs, as requested by the MDH.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the Maryland program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until 1 year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

To help ensure members receive quality services, you must also comply with requests for on-site reviews conducted by the state. During these reviews, the state will address your capability to meet MDH program standards.

You must cooperate with the state or any of its authorized representatives, the MDH, CMS, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Provider Agreement.

These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

We will perform reviews and audits without delaying your work. If you refuse to allow access, this will constitute a breach of your Provider Agreement.

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable Provider Agreement and this manual.

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care (QOC) and services concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PCP office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance
- Available handicapped parking
- Handicapped accessible facility
- Available adequate waiting room space
- Adequate exam rooms for providing member care
- Privacy in exam rooms
- Clearly marked exits
- Accessible fire extinguishers
- Post file inspection record in the last year

Criteria for site visits

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit according to UnitedHealthcare Community Plan policy.

QOS Issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	1 complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	2 complaints in 6 months
Other	All other complaints concerning the office facilities	3 complaints in 6 months

Chapter 11: Billing and Submission

Key contacts

Topic	Link	Phone Number
Claims	**UHCprovider.com/claims**	1-866-633-4449
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov**	1-800-465-3203
EDI	**UHCprovider.com/EDI**	1-866-633-4449

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Facts to know before you bill

You must verify through the Eligibility Verification System (EVS) that participants are assigned to UnitedHealthcare Community Plan before rendering services.

- You are prohibited from balance billing anyone that has Medicaid including MCO members
- You may not bill Medicaid or MCO members for missed appointments
- Medicaid regulations require that a care provider accept payment by the program as payment in full for covered services rendered and make no additional charge to any person for covered services
- Any Medicaid care provider that practices balance billing is in violation of their contract
- For covered services, care providers may only bill us or the Medicaid program if the service is covered by the state but is not covered by the MCO
- You are prohibited from billing any other person, including the Medicaid participant or the participant's family members, for covered services
- HealthChoice participants may not pay for covered services provided by a Medicaid care provider that is outside of their MCO care provider network
- If a service is not a covered service and the member knowingly agrees to receive a non-covered service, the care provider MUST: Notify the member in advance that the charges will not be covered under the program. Require that the member sign a statement agreeing to pay for the services and place the document in the member's medical record. We recommend you call us to verify that the service is not covered before rendering the service.

Our claims process

For claims, billing and payment questions, go to **UHCprovider.com**.

We follow the same claims process as UnitedHealthcare. See the Our Claims Process chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP on **UHCprovider.com/guides**.

Claims: From submission to payment

1 You submit EDI claims to a clearinghouse or paper claims to us. We scan paper claims.	**2** All claims are checked for compliance and validated.
3 Claims are routed to the correct claims system and loaded.	**4** Claims with errors are manually reviewed.
5 Claims are processed based on edits, pricing and member benefits.	**6** Claims are checked, finalized and validated before sending to the state.
7 Adjustments are grouped and processed.	**8** Claims information is copied into data warehouse for analytics and reporting.
9 We make payments as appropriate.	

Claims reconsideration and appeals
If you think we processed your claim incorrectly, please see the Claims Reconsiderations, Appeals and Grievances chapter in this manual for next steps.

National Provider Identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions.

If you have not applied for a NPI, contact **National Plan and Provider Enumeration System (NPPES)**. Once you have an identifier, report it to UnitedHealthcare Community Plan. Call **Provider Services**.

Your clean claims must include your NPI and federal TIN.

Submitting claims to UnitedHealthcare Community Plan

We only consider reimbursing claims if you met billing and coverage requirements. Submitting a referral does not guarantee we will pay you. Payment depends on the member's coverage on the dates of service, medical necessity, plan rules about limitations and exclusions, and UnitedHealthcare Community Plan policies. We don't reimburse excessive, inappropriate or non-covered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for overpayments or offset future payments as allowed by law.

Fee schedule

Reimbursements also depend on the fee schedule and the procedure performed. Refer to your bulletins for correct coding.

Modifier codes

Use the appropriate **modifier codes** on your claim form. The modifier must be used based on the date of service.

Member ID card for billing

The member ID card has the UnitedHealthcare Community Plan member ID (MID). Bill using the MID.

Acceptable claim forms

UnitedHealthcare Community Plan only processes claims submitted on CMS 1500 and UB-04 claim forms.

Use the CMS 1500 form for ancillary services, ambulatory surgery center and urgent care centers.

Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers.

Clean claims and submission requirements

Complete a CMS 1500 or UB-04 form whether you submit an electronic or a paper claim. Clean claims have:

- A health service provided by an eligible health care provider to a covered UnitedHealthcare Community Plan member
- All the required documentation, including correct diagnosis and procedure codes
- The correct amount claimed

We may require additional information for some services, situations or state requirements.

Submit any services completed by NPs or PAs who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims just like other physicians.

Care provider coding

UnitedHealthcare Community Plan complies with EPSDT state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-9 or ICD-10 code.

> For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/en/policies-protocols.html**. Under Additional Resources, choose Protocols > **Social Determinants of Health ICD-10 Coding Protocol**.

Electronic claims submission and billing

You may submit claims by electronic data interchange (EDI). EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

- Our payer ID is 87726
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms

> For more information, contact **EDI Claims**.

EDI companion documents

UnitedHealthcare Community Plan's companion documents are intended to share information within Implementation Guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

- Clarify data content that meets the needs of the health plan's business purposes when the IG allows multiple choices
- Provide values the health plan will return in outbound transactions
- Outline which situational elements the health plan requires

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.

> The companion documents are located on UHCprovider.com/edi > Go to **EDI companion guides**.

Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties.

> For clearinghouse options, use our EDI at UHCprovider.com/EDI > **EDI Clearinghouse Options**.

e-Business support

Call Provider Services for help with online billing, claims, Electronic Remittance Advices (ERAs), and Electronic Funds Transfers (EFTs).

For all of our claims and payment options, such as business support and EDI claims, go to Chapter 1 under Online Services.

> To find more information about EDI online, go to **UHCprovider.com/EDI**.

Electronic payment solution: Optum Pay™

UnitedHealthcare has launched the replacement of paper checks with electronic payments and will no longer be sending paper checks for payment. You will have the option of signing up for Automated Clearing House (ACH)/direct deposit, our preferred method of payment, or to receive a Virtual Card payment (Virtual Card). The only alternative to a Virtual Card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose ACH/direct deposit?

- Direct deposit puts payment directly into your bank account
- Easy and fast way to get paid
- Improved financial control; no paper checks or remittance information to lose or misplace
- Ability to track information on online portal

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/healthcare organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay™ or receiving Virtual Cards there is no action you need to take

- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library.
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**.

All regulated entities have a Management Agreement with United HealthCare Services, Inc. (UHS), under which UHS provides a whole host of administrative services (many of which are provided to UHS by an Optum entity and then passed through to the regulated entities), including those of a financial nature. Those agreements are filed with the DOI in the regulated entity's state of domicile for approval.

Completing the CMS 1500 claim form

> Companion documents for 837 transactions are on **UHCprovider.com/EDI**.

Visit the National Uniform Claim Committee website or view the **2018 Maryland Medical Assistance Program Professional Services Provider Manual** to learn how to complete the CMS 1500 form.

Completing the UB-04 form

Bill all hospital inpatient, outpatient and emergency room services using revenue codes and the UB-04 claim form:
- Include ICD CM diagnosis codes
- Identify other services by the CPT/HCPCS and modifiers

Form reminders

- Note the attending provider name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims

- Send the referring provider NPI and name on outpatient claims when this care provider is not the attending provider
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefit

Our benefits contracts are subject to subrogation and coordination of benefits (COB) rules:

- **Subrogation –** We may recover benefits paid for a member's treatment when a third party causes the injury or illness
- **COB –** We coordinate benefits based on the member's benefit contract and applicable regulations

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

Global days

Global days include the billable period involving pre-operative visits, the procedure itself, and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same care provider or another care provider reporting the same TIN in either an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), or physician's office.

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > For Community Plans > Reimbursement Policies for Community Plan > **Global Days Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan**.

Correct Coding Initiative

For CMS 1500 claims, UnitedHealthcare Community Plan performs coding edit procedures based on the Correct Coding Initiative (CCI) and other nationally recognized sources.

Comprehensive and component codes

Comprehensive and component code combination edits apply when code pairs appear to be related. These edits can be further broken down to explain the bundling rationale. Some of the most common causes for denials in this category are:

- **Separate procedures –** Only report these codes when performed independently
- **Most extensive procedures –** You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services –** Don't report combinations where 1 code includes and the other excludes certain services
- **Medical practice standards –** Services part of a larger procedure are bundled
- **Laboratory panels –** Don't report individual components of panels or multichannel tests separately

Clinical Laboratory Improvements Amendments

Submit your laboratory claims with the Clinical Laboratory Improvements Amendments (CLIA) number. In box 23 of the CMS 1500 claim form, enter the 10-digit CLIA certification number for laboratory services billed by an entity performing CLIA-covered procedures.

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at **1-410-786-3531** or go to the **cms.gov**.

Billing multiple units

When billing multiple units:
- If the same procedure is repeated on the same date of service, enter the procedure code once with the appropriate number of units
- The total bill charge is the unit charge multiplied by the number of units

National Drug Code

Claims must include:
- National Drug Code (NDC) and unit of measurement for the drug billed
- HCPCS/CPT code and units of service for the drug billed
- Actual metric decimal quantity administered

Submit the NDC on all claims with procedure codes for care provider-administered drugs in outpatient clinical settings. The claims must show the NDC that appears on the product. Enter the identifier N4, the 11-digit NDC code, unit/basis of measurement qualified, and metric decimal quantity administered. Include HCPCS/CPT codes.

Medical necessity

UnitedHealthcare Community Plan only pays for medically necessary services. See **Chapter 4** for more information about medical necessity.

Place of Service codes

Go to **CMS.gov** for Place of Service codes.

Billing inquiries

You can ask about claims through UnitedHealthcare Community Plan Provider Services and the UnitedHealthcare Community Plan Provider Portal. To access the portal, go to **UHCprovider.com**. Follow the instructions to get a user ID. You will receive your user ID and password within 48 hours.

Provider Services

Provider Services helps resolve claims issues. Have the following information ready before you call:
- Member's ID number
- Date of service
- Procedure code
- Amount billed
- Your ID number
- Claim number

Allow Provider Services 45 days to solve your concern. Limit phone calls to 5 issues per call.

UnitedHealthcare Community Plan Provider Portal

You can view your online transactions by signing in to the Provider Portal on **UHCprovider.com** with your One Healthcare ID. This portal offers you with online support any time. If you are not already registered, you may do so on the website.

The Provider Portal lets you move quickly between applications. This helps you:
- Check member eligibility
- Submit claims reconsiderations
- Review coordination of benefits information
- Use the integrated applications to complete multiple transactions at once
- Reduce phone calls and paperwork

You can even customize the screen to put these common tasks just 1 click away.

Find Provider Portal training at **UHCprovider.com/training**. Provider Portal training course is available using the **Community Care Provider Portal User Guide**.

Resolving claim issues

To resolve claim issues, contact **Provider Services**, use the Provider Portal or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

> **UnitedHealthcare Community Plan**
> P.O. Box 5240
> Kingston, NY 12402-5240

Allow up to 30 days for UnitedHealthcare Community Plan to receive payment for initial claims and adjustment requests.

For paper claims

Submit a screen shot from your accounting software that shows when you submitted the claim. The screen shot must show the correct:

- Member name.
- Date of service.
- Claim date submission (within the timely filing period).

Timely filing

Timely filing issues may occur if members give the wrong insurance information when you treat them. This results in receiving:

- A denial/rejection letter from another carrier.
- Another carrier's explanation of benefits.
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service.

All of the above must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.

The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

If a claim is rejected, and corrections are not received within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

Timely filing limits can vary based on state requirements and contracts. If you don't know your timely filing limit, refer to your Provider Agreement.

Balance billing

Do not balance bill members if:

- The charge amount and the UnitedHealthcare Community Plan fee schedule differ.
- Your claim is denied for late submission, unauthorized service or as not medically necessary.
- UnitedHealthcare Community Plan is reviewing a claim

You are able to balance bill the member for non-covered services if the member provides written consent prior to getting the service. In addition, you may balance bill the member if no consent was provided and the claim was denied for medical necessity. If you have questions, please contact your provider advocate.

If you don't know who your provider advocate is, email **md_dc_provider_relations@uhc.com**. A provider advocate will get back to you.

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an explanation of benefits (EOB) from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your Agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, the claim may then be submitted to UnitedHealthcare Community Plan. Please attached a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or denial reason.

Chapter 12: Claim Reconsiderations, Appeals and Grievances

Looking for something?
- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCprovider.com**.

The following grid lists the types of disputes and processes that apply:

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS							
SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	FILING OPTIONS	CONTACT PHONE NUMBER	CARE PROVIDER FILING Time frame	UnitedHealthcare Community Plan RESPONSE Time frame
Member Appeal	A request to change an adverse benefit determination that we made.	• Member • *Care provider on behalf of member with member's written consent.	UnitedHealthcare Member Appeals and Grievances P.O. Box 31364 Salt Lake City, UT 84131	Verbal filing, submit appeal request in writing	1-800-318-8821, TTY 711 Monday-Friday 8 a.m. to 7 p.m. ET	60 calendar days from the date on the notice adverse benefit determination	Urgent appeals: Reasonable efforts are made to provide oral and written notice of decision to member, and, if applicable, other affected parties within 1 calendar day of decision. The time frame to resolve an Urgent/expedited appeal is 3 calendar days from receipt. Standard appeals: 30 days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	FILING OPTIONS	CONTACT PHONE NUMBER	CARE PROVIDER FILING Time frame	UnitedHealthcare Community Plan RESPONSE Time frame
Member Grievance	A member's written or oral expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	• Member • Care provider on behalf of member with member's written consent	UnitedHealthcare Member Appeals and Grievances P.O. Box 31364 Salt Lake City, UT 84131	Verbal filing, submit grievance in writing	1-800-318-8821, TTY 711 Monday-Friday 8 a.m. to 7 p.m. ET	N/A	30 calendar days (administrative), 1 calendar day (emergency-related grievances) 5 calendar days (nonemergency, medically related),
Care Provider Claim Resubmission	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission	Care Provider	UnitedHealthcare Community Plan P.O. Box 5240 Kingston, NY 12402	Use Claims Management or Claims on Link. Click "Sign in to Link" in the top right corner of **UHCprovider. com**. Then click "Claims."	1-877-842-3210, Monday-Friday 8 a.m. to 6 p.m., ET	Must receive within 45 business days	30 business days
Care Provider Claim Reconsideration	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	UnitedHealthcare Community Plan Grievance & Appeals Department P.O. Box 31364 Salt Lake City, UT 84131	Use Claims Management or Claims on Link. Click "Sign in to Link" in the top right corner of **UHCprovider. com**. Then click "Claims." If unable to access, mail in **Single Paper Claim Reconsideration Request Form**	1-877-842-3210, Monday-Friday 8 a.m. to 6 p.m., ET	Must receive within 90 business days	30 business days
Care Provider Claim Formal Appeal	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider or Member	UnitedHealthcare Community Plan Grievance & Appeals Department P.O. Box 31364 Salt Lake City, UT 84131-0364	Use Claims Management or Claims on Link. Click "Sign in to Link" in the top right corner of **UHCprovider. com**. Then click "Claims."	1-877-842-3210, Monday-Friday 8 a.m. to 6 p.m., ET	90 business days from the date of the reconsideration notice Second level appeal: 15 business days from the date on the first level appeal notice	First level appeal: 40 calendar days Second level appeal: 35 calendar days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS							
SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	FILING OPTIONS	CONTACT PHONE NUMBER	CARE PROVIDER FILING Time frame	UnitedHealthcare Community Plan RESPONSE Time frame
Care Provider Grievances	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member	Care Provider	UnitedHealthcare Community Plan Grievance & Appeals Department P.O. Box 31364 Salt Lake City, UT 84131-0364	Verbal filing, complete request in writing	1-877-842-3210, Monday-Friday 8 a.m. to 6 p.m., ET	No filing limit	30 calendar days (administrative) If a member's treatment outcome may be significantly affected by the promptness of treatment: 5 calendar days (non-emergency medically related) 1 calendar day (emergency medically related)

*Note: Written consent is not required from a member when a provider files an expedited appeal on behalf of the member.

The definitions and process requirements in the previous grid are subject to modification by state contract or regulations. States may impose more stringent requirements.

UnitedHealthcare Community Plan and its contracted providers may agree to more stringent requirements within provider contracts than described in the standard process.

Provider appeal of UnitedHealthcare Community Plan claim denial

Denial of claims is considered a contractual issue between the MCO and the care provider. You must contact the MCO directly. The Maryland Insurance Administration refers MCO billing disputes to MDH. MDH may assist you in contacting the appropriate representative at **UnitedHealthcare Community Plan**, but MDH cannot compel **UnitedHealthcare Community Plan** to pay claims that UnitedHealthcare Community Plan administratively denied.

Denial

Your claim may be denied for administrative or medical necessity reasons.

- **Administrative denial** – when we didn't get notification before the service, or the notification came in too late
- **Medical necessity** – the level of care billed wasn't approved as medically necessary

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file an appeal.

Other top reasons for denial include:

- **Duplicate claim** – This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.
- **Claim lacks information** – Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.
- **Eligibility expired** – Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the

patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

- **Claim not covered by UnitedHealthcare Community Plan** – Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.
- **Time limit expired** – This is when you don't send the claim in time.

State's independent review organization (IRO)

The Department contracts with an IRO for the purpose of offering you another level of appeal for when you wish to appeal **medical necessity denials** only. You must first exhaust all levels of the MCO appeal process. By using the IRO, you agree to give up all appeal rights (e.g., administrative hearings, court cases). The IRO only charges **after** making the case determination. If the decision upholds the MCO's denial, you must pay the fee. If the IRO reverses the MCO's denial, the MCO must pay the fee. The web portal will walk you through submitting payments. The review fee is $425. More detailed information on the IRO process can be found at **https://health.maryland.gov/mmcp/pages/IRO-Information.aspx**.

The IRO does not accept cases for review which involve disputes between the Behavioral Health ASO and UnitedHealthcare Community Plan.

Claim correction

What is it?

You may need to update information on a claim you've already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to use:

Submit a corrected claim to fix or void one that has already processed.

How to use:

Use the claims reconsideration application on the Provider Portal. To access the Provider Portal, sign in to

UHCprovider.com using your One Healthcare ID. You may also mail the claim with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

> **UnitedHealthcare Community Plan**
> P.O. Box 5240
> Kingston, NY 12402-5240

Additional Information:

When correcting or submitting late charges on 837 institutional claims, use bill type xx7: Replacement of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim. To void a claim, use bill type xx8.

Resubmitting a claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected. Since rejected claims have not been processed yet, there is no appeal - the claim needs to be corrected through resubmission.

Common reasons for rejected claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address
- Errors in care provider data
- Wrong member insurance ID
- No referring care provider ID or NPI number

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information to:

> **UnitedHealthcare Community Plan**
> P.O. Box 5240
> Kingston, NY 12402-5240

Claim reconsideration

What is it?

Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with. A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly. When you send a reconsideration, please send additional support information.

When to use:

Reconsiderations can be done repeatedly, but should include new information each time. Submit a claim reconsideration when you think a claim has not been properly processed.

For administrative denials – In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.

For medical necessity denials:

- In your request, please include any additional clinical information that may not have been reviewed with your original claim
- Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation

How to use:

If you disagree with a claim determination, submit a claim reconsideration request electronically, by phone or by mail:

- **Electronically** – Use the Claim Reconsideration application on the Provider Portal. Include electronic attachments. You may also check your status using the portal.
- **Phone** – Call Provider Services at **1-877-842-3210**, Monday-Friday, 8 a.m. to 6 p.m., (ET) or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- **Mail** – Submit the Claim Reconsideration Request Form to:

  UnitedHealthcare Community Plan
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

  This form is available at **UHCprovider.com/claims**.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-Claim Appeal.

A copy of the form is online at **UHCprovider.com**.

Valid proof of timely filing documentation (reconsideration)

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service. It includes:

- A denial or rejection letter from another insurance carrier

- Another insurance carrier's explanation of benefits
- Letter from another insurance carrier or employer group indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request electronically, phone or mail with the following information:

- **Electronic claims** – Include the EDI acceptance report stating we received your claim
- **Mail reconsiderations** – Submit a screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
  - Correct member name
  - Correct date of service
  - Claim submission date

Additional Information:

Timely filing limits can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Provider Agreement.

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, send an Overpayment Return Check or the Overpayment Refund/Notification form. Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions
- Member identification number
- Date of service
- Original claim number (if known)
- Date of payment
- Amount paid
- Amount of overpayment
- Overpayment reason
- Check number

Where to send:

Mail refunds with an Overpayment Return Check or the Overpayment Refund/Notification form to:

> **UnitedHealthcare Community Plan**
> ATTN: Recovery Services
> P.O. Box 740804
> Atlanta, GA 30374-0800

Instructions and forms are on **UHCprovider.com/claims**.

If you do not agree with the overpayment findings, submit a dispute within the required time frame as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See Dispute section in this chapter.

We make claim adjustments without requesting additional information from you. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional information is needed, we will ask you to provide it.

Appeals

What is it?

An appeal is a review of a reconsideration claim. It is a one-time formal review of a processed claim that was partially paid or denied.

When to use:

If you do not agree with the outcome of the Appeals

Sample overpayment report

*The information provided is sample data only for illustrative purposes. Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	14A000000001	01/31/14	115.03	115.03	Double payment of claim
2222222	02/02/14	14A000000002	03/15/14	279.34	27.19	Contract states $50, claim paid 77.29
3333333	03/03/14	14A000000003	04/01/14	131.41	99.81	You paid 4 units, we billed only 1
44444444	04/04/14	14A000000004	05/02/14	412.26	412.26	Member has other insurance
55555555	05/05/14	14A000000005	06/15/14	332.63	332.63	Member terminated

What is it?

An appeal is a second review of a reconsideration claim.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step one, use the claim appeal process.

How to use/file:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Send your information electronically or by mail. In your appeal, please include any supporting information not included with your reconsideration request.

- **Electronic claims** – Use the claims tools on the Provider Portal. You may upload attachments.
- **Mail** – Send the appeal to:

      UnitedHealthcare Community Plan
      Grievances and Appeals
      P.O. Box 31364
      Salt Lake City, UT 84131-0364

Questions about your appeal or need a status update? Call Provider Services.

If you filed your appeal online, you should receive a confirmation email or feedback through the secure provider portal link.

Overview of member complaint, grievance and appeal processes

UnitedHealthcare's Member Services line, **800-318-8821** (TTY 711), operates Monday-Friday 8 a.m. to 7 p.m. Member Services resolves or properly refers members' inquiries or complaints to the state or other agencies. UnitedHealthcare Community Plan informs members and care providers of the grievance system processes for complaints, grievances, appeals, and Maryland State Fair Hearings. This information is contained in the Member Handbook and is available on the UnitedHealthcare Community Plan website at **UHCCommunityPlan.com**.

Members or their authorized representatives can file an appeal or a grievance with UnitedHealthcare Community Plan orally or in writing. An authorized representative is someone who assists with the appeal on the

member's behalf, including but not limited to a family member, friend, guardian, care provider, or an attorney. Representatives must be designated in writing. Providers will not be penalized for advising or advocating on behalf of an enrollee.

Members and their representatives may also request any of the following information from UnitedHealthcare Community Plan, free of charge, to help with their appeal by calling Member Services at **1-800-318-8821** (TTY 711), Monday-Friday 8 a.m. to 7 p.m.:

- Medical records;
- Any benefit provision, guideline, protocol, or criterion UnitedHealthcare Community Plan used to make its decision;
- Oral interpretation and written translation assistance; and
- Assistance with filling out UnitedHealthcare Community Plan of Maryland's appeal forms.

UnitedHealthcare Community Plan will take no punitive action for:

- Members requesting appeals or grievances
- Care providers requesting expedited resolution of appeals or grievances
- Care providers supporting a member's appeal or grievance
- Members or care providers making complaints against UnitedHealthcare Community Plan or the Department

UnitedHealthcare Community Plan will also verify that no care provider or facility takes punitive action against a member or care provider for using the appeals and grievance system. You may not discriminate or initiate disenrollment of a member for filing a complaint, grievance, or appeal with UnitedHealthcare Community Plan.

Our internal complaint materials are developed in a culturally sensitive manner, at a suitable reading comprehension level, and in the member's native language if the member is a member of a substantial minority. UnitedHealthcare Community Plan delivers a copy of its complaint policy and procedures to each new member at the time of initial enrollment, and at any time upon a member's request.

MCO member grievance procedures

A grievance is a complaint about a matter that cannot be appealed. Grievance subjects may include but are not limited to dissatisfaction with access to coverage, any internal process or policy, actions or behaviors of our employees, vendors or care provider office teams, care or treatment received from a care provider, and drug utilization review programs applying drug utilization review standards.

Examples of reasons to file an administrative grievance include:

- The member's care provider's office was dirty, understaffed, or difficult to access
- The care provider was rude or unprofessional
- The member cannot find a conveniently located care provider for their health care needs
- The member is dissatisfied with the help they received from the care provider's staff or UnitedHealthcare Community Plan

Examples of reasons to file a medical grievance include:

- The member is having issues with filling their prescriptions or contacting the care provider
- The member does not feel they are receiving the right care for their condition
- UnitedHealthcare Community Plan is taking too long to resolve the member's appeal or grievance about a medical issue
- UnitedHealthcare Community Plan denies the member's request to expedite their appeal about a medical issue

Grievances may be filed at any time with UnitedHealthcare Community Plan orally or in writing by the member or their authorized representative, including care providers. UnitedHealthcare Community Plan responds to grievances within the following time frames:

- 30 calendar days of receipt for an administrative (standard) grievance
- 5 calendar days of receipt for an urgent (medically related) grievance
- 1 calendar day of receipt for an emergent or an expedited grievance

If we are unable to resolve an urgent or administrative grievance within the specified time frame, we may extend the time frame of the grievance by up to 14 calendar days if the member requests the extension or

if we demonstrate to the satisfaction of the Maryland Department of Health (MDH), upon its request, that there is need for additional information and how the delay is in the member's interest. In these cases, we will attempt to reach you and the member by phone to provide information describing the reason for the delay and will follow with a letter within 2 calendar days detailing the reasons for our decision to extend.

For expedited grievances, UnitedHealthcare Community Plan will make reasonable efforts to provide oral notice of the grievance decision and will follow the oral notice with written notification. Members are advised in writing of the outcome of the investigation of all grievances within the specified processing time frame. The Notice of Resolution includes the decision reached, the reasons for the decision, and the telephone number and address where the member can speak with someone regarding the decision. The notice also tells members how to ask the state to review our decision and to obtain information on filing a request for a State Fair Hearing, if applicable.

Member appeal procedures

An appeal is a review by the MCO or the Department when a member is dissatisfied with a decision that impacts their care. Reasons a member may file an appeal include:

- UnitedHealthcare Community Plan denies covering a service ordered or prescribed by the member's care provider. The reasons a service might be denied include:
  - The treatment is not needed for the member's condition or would not help you in diagnosing the member's condition
  - Another more effective service could be provided instead
  - The service could be offered in a more appropriate setting, such as a care provider's office instead of the hospital
- UnitedHealthcare Community Plan limits, reduces, suspends or stops a service that a member is already receiving. For example:
  - The member has been getting physical therapy for a hip injury and they have reached the frequency of physical therapy visits allowed
  - The member has been prescribed a medication, it runs out, and they do not receive any more refills for the medication

- UnitedHealthcare Community Plan denies all or part of payment for a service a member has received, and the denial was not related to the claim being "clean"
- UnitedHealthcare Community Plan fails to provide services in a timely manner, as defined by the Department (for example, it takes too long to authorize a service a member or their care provider requested)
- UnitedHealthcare Community Plan denies a member's request to speed up (or expedite) the resolution about a medical issue

The member will receive a Notice of Adverse Benefit Determination (also known as a denial letter) from us. The Notice of Adverse Benefit Determination informs the member of the following:

- UnitedHealthcare Community Plan's decision and the reasons for the decision, including the policies or procedures which provide the basis for the decision
- A clear explanation of further appeal rights and the time frame for filing an appeal
- The availability of assistance in filing an appeal
- The procedures for members to exercise their rights to an appeal and request a State Fair Hearing if they remain dissatisfied with UnitedHealthcare Community Plan's decision
- That members may represent themselves or designate a legal counsel, a relative, a friend, a care provider or other spokesperson to represent them, in writing
- The right to request an expedited resolution and the process for doing so
- The right to request a continuation of benefits and the process for doing so

If the member wants to file an appeal with UnitedHealthcare Community Plan, they have to file it within 60 days from the date of the denial letter. Our denial letters must include information about the HealthChoice Help Line. If the member has questions or needs assistance, direct them to call **1-800-284-4510**. You may call the state's HealthChoice Provider Help Line at **1-800-766-8692**. If you would like to appeal a decision on a member's behalf, you must obtain the member's consent to appeal in writing and submit it to us.

When the member files an appeal, or at any time during our review, the member and/or care provider should

provide us with any new information that will help us make our decision. The member or representative may ask for up to 14 additional days to gather information to resolve the appeal. If the member or representative needs more time to gather information to help UnitedHealthcare Community Plan make a decision, they may call UnitedHealthcare Community Plan at **1-800-318-8821** (TTY 711), Monday-Friday 8 a.m. to 7 p.m. for assistance and ask for an extension.

UnitedHealthcare Community Plan may also request up to 14 additional days to resolve the appeal if we need to get additional information from other sources. If the MCO requests an extension, the MCO will send the member a letter and call the member and their care provider.

When reviewing the member's appeal, we will:

- Use doctors with appropriate clinical expertise in treating the member's condition or disease
- Not use the same MCO staff to review the appeal who denied the original request for service
- Make a decision within 30 days, if the member's ability to attain, maintain, or regain maximum function is not at risk

On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where a member's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating care provider, the member's condition cannot be adequately managed without urgent care or services. UnitedHealthcare Community Plan resolves expedited appeals effectively and efficiently as the member's health requires. Written confirmation or the member's written consent is not required to have the care provider act on the member's behalf for an expedited appeal. If the appeal needs to be reviewed quickly due to the seriousness of the member's condition, and UnitedHealthcare Community Plan agrees, the member will receive a decision about their appeal as expeditiously as the member health condition requires or no later than 1 calendar day from the request. If an appeal does not meet expedited criteria, it will automatically be transferred to a standard time frame. UnitedHealthcare Community Plan will make a reasonable effort to provide verbal notification and will send written notification within 2 calendar days.

Once we complete our review, we will send the member a letter letting them know our decision. UnitedHealthcare Community Plan will send written notification for a standard appeal time frame, including an explanation for the decision, **within 2 business days of the decision**.

For an expedited appeal time frame, UnitedHealthcare Community Plan will communicate the decision verbally at the time of the decision and in writing, including an explanation for the decision, within 1 calendar day of the decision.

If we decide that they should not receive the denied service, that letter will tell them how to ask for a State Fair Hearing.

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses the CMS definitions for appeals and grievances.

Request to continue benefits during the appeal

If the member's appeal is about ending, stopping, or reducing a service that was authorized, they may be able to continue to receive the service while we review their appeal. Providers may not request to continue benefits on the member's behalf. The member should contact us within 10 calendar days of the mailing date of the notice of adverse benefit determination at **1-800-318-8821 (TTY 711)**, Monday-Friday 8 a.m.-7 p.m. if they would like to continue receiving services while their appeal is reviewed (COMAR 10.67.09.05(B)(4)). The service or benefit will continue until either the member withdraws the appeal or the appeal or fair hearing decision is adverse to the member. If the member does not win their appeal, they may have to pay for the services that they received while the appeal was being reviewed.

Members or their designated representative may request to continue to receive benefits while the State Fair Hearing is pending. Benefits will continue if the request meets the criteria described above when the member receives the MCO's appeal determination notice and decides to file for a State Fair Hearing. If UnitedHealthcare Community Plan or the Maryland Fair Hearing officer does not agree with the member's appeal, the denial is upheld, **and the member continues to receive services**, the member may be responsible for the cost of services received during the review. If either

rendering party overturns UnitedHealthcare Community Plan's denial, we will authorize and cover the costs of the service within 1 calendar day of notification.

State fair hearing rights

A HealthChoice member may exercise their State Fair Hearing rights, but the member must first file an appeal with UnitedHealthcare Community Plan. If UnitedHealthcare Community Plan upholds the denial the member may appeal to the Office of Administrative Hearings (OAH) by contacting the HealthChoice Help Line at **1-800-284-4510**. If the member decides to request a State Fair Hearing, we will continue to work with the member and the care provider to attempt to resolve the issue prior to the hearing date.

If a hearing is held and the Office of Administrative Hearings decides in the member's favor, UnitedHealthcare Community Plan will authorize or provide the service no later than 1 calendar day of being notified of the decision. If the decision is adverse to the member, the member may be liable for services continued during our appeal and State Fair Hearing process. The final decision of the Office of Administrative Hearings is appealable to the Circuit Court, and is governed by the procedures specified in State Government Article, §10-201 et seq., Annotated Code of Maryland.

State HealthChoice help lines

If a member has questions about the HealthChoice Program or the actions of UnitedHealthcare Community Plan direct them to call the state's HealthChoice Help Line at **1-800-284-4510**. Providers can contact the HealthChoice Provider Line at **1-800-766-8692**.

Fraud, waste and abuse activities

Call the **Fraud, Waste and Abuse Hotline** to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high- risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.

Find out how we follow federal and state regulations around false claims at UHCprovider.com/MDcommunityplan > **Integrity of Claims, Reports, and Representations to the Government.**

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational

mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

Reporting suspected fraud and abuse

Participating care providers are required to report to UnitedHealthcare Community Plan all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

You can report suspected fraud and abuse in the following ways:

- **By phone or online –** UnitedHealth Group Fraud Hotline: **1-844-359-7736** or **uhc.com/fraud**
- **In writing –**

  Maryland Department of Health
  Office of the Inspector General
  Program Integrity Division
  201 W. Preston Street
  Baltimore, MD 21201
- **Fax – 1-410-333-7194**
- **Email – MDH.OIG@Maryland.gov**

You can also report care provider fraud to the MDH Office of the Inspector General at **1-410-767-5784** or **1-866-770-7175**), the Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General, at 1-**410-576-6521 (1-888-743-0023)** or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS (1-800-447-8477)**.

The Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General created by statute to preserve the integrity of the Medicaid program by conducting and coordinating Fraud, Waste, and Abuse control activities for all Maryland agencies responsible for services funded by Medicaid.

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must

review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- **Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)**
- **General Services Administration (GSA) System for Award Management**

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Relevant laws

There are several relevant laws that apply to Fraud, Waste, and Abuse:

The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when health care providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:

- Knowingly presenting a false or fraudulent claim for payment or approval
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The Self-Referral Prohibition Statute (Stark Law) prohibits care providers from referring members to an entity with which the care provider or their immediate family member has a financial relationship, unless an exception applies.

The Red Flag Rule (Identity Theft Protection) requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.

The Health Insurance Portability and Accountability Act (HIPAA) requires:

- Transaction standards
- Minimum security requirements
- Minimum privacy protections for protected health information
- National Provider Identification (NPIs) numbers

The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families accessing UnitedHealthcare Community Plan services through Maryland HealthChoice.

Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), UnitedHealthcare Community Plan care providers will follow federal and Maryland laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs, including programs for children and families accessing UnitedHealthcare Community Plan services through Maryland HealthChoice.

Under the Maryland False Claims Act, Md. Code Ann., Health General §2-601 et. seq. **Administrative sanctions** can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid care provider number application (if applicable)

- Suspension of care provider payments
- Being added to the OIG List of Excluded Individuals/Entities database
- License suspension or revocation

Remediation may include any or all of the following:

- Education
- Administrative sanctions
- Civil litigation and settlements
- Criminal prosecution
- Automatic disbarment
- Prison time

Exclusion lists and death master report

UnitedHealthcare Community Plan is required to check the Office of the Inspector General (OIG), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), the Social Security Death Master Report, and any other such databases as the Maryland MMA Providers and other Entities Sanctioned List may prescribe.

UnitedHealthcare Community Plan does not participate with or enter into any care provider agreement with any individual, or entity that has been excluded from participation in federal health care programs, who have a relationship with excluded care providers or who have been terminated from the Medicaid, or any programs by Maryland Department of Health for fraud, waste, or abuse. The care provider must agree to assist UnitedHealthcare Community Plan as necessary in meeting our obligations under the contract with the Maryland Department of Health to identify, investigate, and take appropriate corrective action against fraud, waste, and abuse (as defined in 42 C.F.R. 455.2) in the provision of health care services.

Additional resources

To access the current list of Maryland sanctioned care providers follow this link: **mmcp.health.maryland.gov**.

Chapter 13: Care Provider Communications and Outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Resources > **Resource Library**	
News and Bulletins	UHCprovider.com > Resources > **News**	1-877-842-3210
Provider Manuals	**UHCprovider.com/guides**	

Looking for something else?
- In PDF view, click CTRL+F, then type the keyword
- In web view, type your keyword in the "what can we help you find?" search bar

Connect with us on social media:

Communication with care providers

UnitedHealthcare is on a **multi-year effort** to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes; news and other important updates.

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- **UHCprovider.com**–This public website is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.
- **UHCprovider.com/MDcommunityplan**–The UnitedHealthcare Community Plan of Maryland page has state-specific resources, guidance and rules

- **Policies and protocols**–UHCprovider.com > Resources > Health Plans, Policies, Protocols and Guides > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **Maryland health plans**–**UHCprovider.com/MD** is the fastest way to review all of the health plans UnitedHealthcare offers in Maryland. To review plan information for another state, use the drop-down menu at UHCprovider.com > Resources > **Health Plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Provider Portal**–This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  You can learn more about the portal in **Chapter 1** of this manual or by visiting **UHCprovider.com/portal**. You can also access UHCprovider.com/training > **Digital Solutions** for many of the tools and tasks available in the portal.

- **UnitedHealthcare Network News–**Bookmark UHCprovider.com > Resources > **News**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans. You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients. This includes the communication formerly known as the Network Bulletin.

Receive personalized Network News emails twice a month by subscribing at **cloud.provideremail.uhc.com/subscribe**. You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the UnitedHealthcare Provider Portal, plan and product overviews, clinical tools and state-specific training.

View the training resources at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the UnitedHealthcare Provider Portal
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.

Already have a One Healthcare ID? To review or update your email, simply sign in to the portal. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

If you are not sure who your provider advocate is, you can view a map to determine which provider advocate to contact based on your location at **UHCprovider.com/MDcommunityplan** > Contact Us.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

AABD
Assistance to the aged, blind and disabled

Abuse (by care provider)
Care provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 455.2.

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Action
The denial or limited authorization of a requested service, including the type, level or care provider of service; reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:
- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Advance Directive
Legal papers that list a member's wishes about their end-of-life health care.

Ambulatory Care
Health care services that do not involve spending the night in the hospital. Also called "outpatient care." Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility
A state facility that is licensed, equipped and operated to provide surgeries and obstetrical deliveries. Members can leave the facility the same day surgery or delivery occurs.

Ancillary Provider Services
Extra health services, like laboratory work and physical therapy, which a member gets in the hospital.

Appeal
A member request that their health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Authorization
Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered. Used interchangeably with "prior authorization."

Billed Charges
Charges you bill for rendering services to a UnitedHealthcare Community Plan member.

Capitation
A prepaid, periodic payment to providers, based upon the number of assigned members made to a care provider for providing covered services for a specific period.

Case Manager
The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member's representative and the member's primary care provider (PCP).

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs.

CHIP
Children's Health Insurance Program.

Clean Claim
A claim with no defect (including lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payment.

CMS
Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

Contracted Health Professionals
PCPs, specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan. These care providers deliver specific covered services to members. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Coordination of Benefits (COB)
A process of figuring out which of 2 or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Covered Services
The portion of a medical, dental or vision expense that a health insurance or plan has agreed to pay for or reimburse.

Credentialing
The verification of applicable licenses, certifications and experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements.

Current Procedural Terminology (CPT) Codes
A code assigned to a task or service a health care provider does for a member. Every medical task or service has its own CPT code. These codes are used by the insurer to know how much they need to pay the physician. CPT codes are created and published by the American Medical Association.

Delivery System
The mechanism by which health care is delivered to a member. Examples include hospitals, provider offices and home health care.

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:
- The difference between billed charges and in-network rates
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits

Discharge Planning
Screening eligible candidates for continuing care following treatment in an acute care facility. It involves care planning, scheduling, arranging and steps that move a member from one level of care to another.

Disenrollment
The discontinuance of a member's eligibility to receive covered services from a contractor.

Dispute
A disagreement involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, mental health and hearing. They also include any medically necessary services found during the preventive exam.

Electronic Data Interchange (EDI)
The electronic exchange of information between 2 or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between 2 or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member's health record and the care they have received.

Eligibility Determination
Deciding whether an applicant meets the requirements for federal or state eligibility.

Emergency Care
The provision of medically necessary services required for immediate attention to review or stabilize a medical emergency.

Encounter
A record of health care-related services by care providers registered with Medicaid to a patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment
The process where a person is determined eligible to receive Medicaid or Medicare benefits becomes an enrollee or member of a health plan.

Evidence-Based Care
An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited Appeal
An oral or written request by a member or member's representative received by UnitedHealthcare Community Plan requesting a faster reconsideration of an action. This speed is necessary when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Grievance
A grievance where delay in resolution could harm the member's health or life.

Fee For Service (FFS)
A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FHC
Family Health Center

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

Grievance
An oral or written complaint a member or their representative has and communicates to UnitedHealthcare Community Plan.

Healthcare Effectiveness Data and Information Set (HEDIS®)
A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

HIPAA
Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding health information.

Home Health Care (Home Health Services)
Health care services and supplies provided in the home, under physician's orders. Services may be provided by nurses, therapists, social workers or other licensed health care providers. Home health care usually does not include help with nonmedical tasks, such as cooking, cleaning or driving.

In-Network Care Provider
A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement.

Medicaid
A federal health insurance program for low-income families and children, eligible pregnant members, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

Medical Emergency
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:

- Their health would be put in danger
- They would have serious problems with their bodily functions
- They would have serious damage to any part or organ of their body

Medically Necessary
Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Member
An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

NPI
National Provider Identifier. Required by CMS for all care providers who bill, prescribe or refer for health care services and is used on all electronic transactions. It is a single unique provider identifier assigned to a care provider for life that replaces all other health care provider identifiers. It does NOT replace your DEA number.

Out-Of-Area Care
Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

Preventive Health Care
Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary Care Provider (PCP)
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services.

Prior Authorization (Notification)
The process where health care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy.

Provider Group
A partnership, association, corporation, or other group of care providers.

Quality Management (QM)
A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Rural Health Clinic
A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive enhanced payments for services provided to enrolled members.

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by Maryland DHHS.

Specialist
A care provider licensed in the state of Maryland and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A nonphysician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the member or care provider does not agree with a Notice of Decision or Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

TANF
Temporary Assistance to Needy Families. A state program that gives cash assistance to low-income families with children.

Third-Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.

Chapter 15: Attachments

1. Rare and Expensive Case Management Program with list of qualifying diagnoses
2. School Based Health Center Health Visit Report (DHMH 2015)
3. Local Health ACCU and NEMT Transportation-Contact List
4. Local Health Service Request Form (DHMH 4682)-fillable form
5. Maryland Prenatal Risk Assessment Form (DHMH 4850)
6. Health Insurance Claim Form-CMS 1500
7. UB 04 (CMS 1450)
8. Provider Reportable Communicable Diseases
9. Schedule of Preventive Screenings
10. Maryland Healthy Kids Preventive Health Schedule

Attachment 1

RARE AND EXPENSIVE CASE MANAGEMENT (REM) PROGRAM

The Maryland Department of Health (MDH) administers a Rare and Expensive Case Management (REM) program as an alternative to the MCO for certain HealthChoice eligible individuals diagnosed with rare and expensive medical conditions.

Medicaid Benefits and REM Case Management

To qualify for the REM program, the HealthChoice enrollee must have one or more of the diagnoses specified in the Rare and Expensive Disease List below. The enrollee may elect to enroll in the REM Program, or to remain in **[MCO Name]** if the Department agrees that it is medically appropriate. REM participants are eligible for all fee-for-service benefits currently offered to Medicaid-eligible beneficiaries who not eligible to enroll in MCOs. In addition REM participants may receive additional services which are described in COMAR 10.09.69.

The participant's REM case manager will:
Gather all relevant information needed to complete a comprehensive needs assessment;
Assist the participant select an appropriate PCP, if needed;
Consult with a multi-disciplinary team that includes providers, participants, and family/care givers, and develop the participant's plan of care;
Implement the plan of care, monitor service delivery, modify the plan as warranted by changes in the participant's condition;
Document findings and maintain clear and concise records;
Assist in the participant's transfer out of the REM program, when and if appropriate.

Referral and Enrollment Process

Candidates for REM are generally referred by their PCP, specialty providers, MCOs, but may also self-identify. The referral must include a physician's signature and the required supporting documentation for the qualifying diagnosis(es). A registered nurse reviews the medical information: in order to determine the member's eligibility for REM. If the intake nurse determines that there is no qualifying REM diagnosis, the application is sent to the REM physician advisor for a second level review before a denial notice is sent to the member and referral source. If the member does not meet the REM criteria, they will remain enrolled in the MCO

If the intake nurse determines that the enrollee has a REM-qualifying diagnosis, the nurse approves the member for enrollment in REM. Before the enrollment is completed, the Intake Unit contacts the PCP to see if he/she will continue providing services through the Medicaid fee-for service program. If the PCP is unwilling to continue to care for the member the case is referred to a case manager to select a PCP in consultation with the member. If the PCP will continue providing services, the Intake Unit explain the program and give the member an opportunity to refuse REM enrollment. If enrollment is refused, the member remains in the MCO. The MCO is responsible for providing the member's care until the REM enrollment process is complete.

For questions and referral forms call 800-565-8190; forms may be faxed to 410-333-5426 or mailed to:
REM Intake Unit
Maryland Department of Health
201 W. Preston Street, Room 210
Baltimore, MD 21201-2399

Table of Rare and Expensive Diagnosis

ICD10	ICD 10 Description	AGE LIMIT
B20	Human immunodeficiency virus (HIV) disease	0-20
C96.0	Multifocal and multisystemic Langerhans-cell histiocytosis	0-64
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis	0-64
C96.6	Unifocal Langerhans-cell histiocytosis	0-64
D61.01	Constitutional (pure) red blood cell aplasia	0-20
D61.09	Other constitutional aplastic anemia	0-20
D66	Hereditary factor VIII deficiency	0-64
D67	Hereditary factor IX deficiency	0-64
D68.0	Von Willebrand's disease	0-64
D68.1	Hereditary factor XI deficiency	0-64
D68.2	Hereditary deficiency of other clotting factors	0-64
E70.0	Classical phenylketonuria	0-20
E70.1	Other hyperphenylalaninemias	0-20
E70.20	Disorder of tyrosine metabolism, unspecified	0-20
E70.21	Tyrosinemia	0-20
E70.29	Other disorders of tyrosine metabolism	0-20
E70.30	Albinism, unspecified	0-20
E70.40	Disorders of histidine metabolism, unspecified	0-20
E70.41	Histidinemia	0-20
E70.49	Other disorders of histidine metabolism	0-20
E70.5	Disorders of tryptophan metabolism	0-20
E70.8	Other disorders of aromatic amino-acid metabolism	0-20
E71.0	Maple-syrup-urine disease	0-20
E71.110	Isovaleric acidemia	0-20
E71.111	3-methylglutaconic aciduria	0-20
E71.118	Other branched-chain organic acidurias	0-20
E71.120	Methylmalonic acidemia	0-20
E71.121	Propionic acidemia	0-20
E71.128	Other disorders of propionate metabolism	0-20
E71.19	Other disorders of branched-chain amino-acid metabolism	0-20
E71.2	Disorder of branched-chain amino-acid metabolism, unspecified	0-20
E71.310	Long chain/very long chain acyl CoA dehydrogenase deficiency	0-64
E71.311	Medium chain acyl CoA dehydrogenase deficiency	0-64
E71.312	Short chain acyl CoA dehydrogenase deficiency	0-64
E71.313	Glutaric aciduria type II	0-64
E71.314	Muscle carnitine palmitoyltransferase deficiency	0-64
E71.318	Other disorders of fatty-acid oxidation	0-64
E71.32	Disorders of ketone metabolism	0-64
E71.39	Other disorders of fatty-acid metabolism	0-64
E71.41	Primary carnitine deficiency	0-64
E71.42	Carnitine deficiency due to inborn errors of metabolism	0-64
E71.50	Peroxisomal disorder, unspecified	0-64

E71.510	Zellweger syndrome	0-64
E71.511	Neonatal adrenoleukodystrophy	0-64
E71.518	Other disorders of peroxisome biogenesis	0-64
E71.520	Childhood cerebral X-linked adrenoleukodystrophy	0-64
E71.521	Adolescent X-linked adrenoleukodystrophy	0-64
E71.522	Adrenomyeloneuropathy	0-64
E71.528	Other X-linked adrenoleukodystrophy	0-64
E71.529	X-linked adrenoleukodystrophy, unspecified type	0-64
E71.53	Other group 2 peroxisomal disorders	0-64
E71.540	Rhizomelic chondrodysplasia punctata	0-64
E71.541	Zellweger-like syndrome	0-64
E71.542	Other group 3 peroxisomal disorders	0-64
E71.548	Other peroxisomal disorders	0-64
E72.01	Cystinuria	0-20
E72.02	Hartnup's disease	0-20
E72.03	Lowe's syndrome	0-20
E72.04	Cystinosis	0-20
E72.09	Other disorders of amino-acid transport	0-20
E72.11	Homocystinuria	0-20
E72.12	Methylenetetrahydrofolate reductase deficiency	0-20
E72.19	Other disorders of sulfur-bearing amino-acid metabolism	0-20
E72.20	Disorder of urea cycle metabolism, unspecified	0-20
E72.21	Argininemia	0-20
E72.22	Arginosuccinic aciduria	0-20
E72.23	Citrullinemia	0-20
E72.29	Other disorders of urea cycle metabolism	0-20
E72.3	Disorders of lysine and hydroxylysine metabolism	0-20
E72.4	Disorders of ornithine metabolism	0-20
E72.51	Non-ketotic hyperglycinemia	0-20
E72.52	Trimethylaminuria	0-20
E72.53	Primary Hyperoxaluria	0-20
E72.59	Other disorders of glycine metabolism	0-20
E72.81	Disorders of gamma aminobutyric acid metabolism	0-20
E72.89	Other specified disorders of amino-acid metabolism	0-20
E74.00	Glycogen storage disease, unspecified	0-20
E74.01	von Gierke disease	0-20
E74.02	Pompe disease	0-20
E74.03	Cori disease	0-20
E74.04	McArdle disease	0-20
E74.09	Other glycogen storage disease	0-20
E74.12	Hereditary fructose intolerance	0-20
E74.19	Other disorders of fructose metabolism	0-20
E74.21	Galactosemia	0-20
E74.29	Other disorders of galactose metabolism	0-20
E74.4	Disorders of pyruvate metabolism and gluconeogenesis	0-20

E75.00	GM2 gangliosidosis, unspecified	0-20
E75.01	Sandhoff disease	0-20
E75.02	Tay-Sachs disease	0-20
E75.09	Other GM2 gangliosidosis	0-20
E75.10	Unspecified gangliosidosis	0-20
E75.11	Mucolipidosis IV	0-20
E75.19	Other gangliosidosis	0-20
E75.21	Fabry (-Anderson) disease	0-20
E75.22	Gaucher disease	0-20
E75.23	Krabbe disease	0-20
E75.240	Niemann-Pick disease type A	0-20
E75.241	Niemann-Pick disease type B	0-20
E75.242	Niemann-Pick disease type C	0-20
E75.243	Niemann-Pick disease type D	0-20
E75.248	Other Niemann-Pick disease	0-20
E75.25	Metachromatic leukodystrophy	0-20
E75.26	Sulfatase deficiency	0-20
E75.29	Other sphingolipidosis	0-20
E75.3	Sphingolipidosis, unspecified	0-20
E75.4	Neuronal ceroid lipofuscinosis	0-20
E75.5	Other lipid storage disorders	0-20
E76.01	Hurler's syndrome	0-64
E76.02	Hurler-Scheie syndrome	0-64
E76.03	Scheie's syndrome	0-64
E76.1	Mucopolysaccharidosis, type II	0-64
E76.210	Morquio A mucopolysaccharidoses	0-64
E76.211	Morquio B mucopolysaccharidoses	0-64
E76.219	Morquio mucopolysaccharidoses, unspecified	0-64
E76.22	Sanfilippo mucopolysaccharidoses	0-64
E76.29	Other mucopolysaccharidoses	0-64
E76.3	Mucopolysaccharidosis, unspecified	0-64
E76.8	Other disorders of glucosaminoglycan metabolism	0-64
E77.0	Defects in post-translational mod of lysosomal enzymes	0-20
E77.1	Defects in glycoprotein degradation	0-20
E77.8	Other disorders of glycoprotein metabolism	0-20
E79.1	Lesch-Nyhan syndrome	0-64
E79.2	Myoadenylate deaminase deficiency	0-64
E79.8	Other disorders of purine and pyrimidine metabolism	0-64
E79.9	Disorder of purine and pyrimidine metabolism, unspecified	0-64
E80.3	Defects of catalase and peroxidase	0-64
E84.0	Cystic fibrosis with pulmonary manifestations	0-64
E84.11	Meconium ileus in cystic fibrosis	0-64
E84.19	Cystic fibrosis with other intestinal manifestations	0-64
E84.8	Cystic fibrosis with other manifestations	0-64
E84.9	Cystic fibrosis, unspecified	0-64

E88.40	Mitochondrial metabolism disorder, unspecified	0-64
E88.41	MELAS syndrome	0-64
E88.42	MERRF syndrome	0-64
E88.49	Other mitochondrial metabolism disorders	0-64
E88.89	Other specified metabolic disorders	0-64
F84.2	Rett's syndrome	0-20
G11.0	Congenital nonprogressive ataxia	0-20
G11.1	Early-onset cerebellar ataxia	0-20
G11.2	Late-onset cerebellar ataxia	0-20
G11.3	Cerebellar ataxia with defective DNA repair	0-20
G11.4	Hereditary spastic paraplegia	0-20
G11.8	Other hereditary ataxias	0-20
G11.9	Hereditary ataxia, unspecified	0-20
G12.0	Infantile spinal muscular atrophy, type I (Werdnig-Hoffman)	0-20
G12.1	Other inherited spinal muscular atrophy	0-20
G12.21	Amyotrophic lateral sclerosis	0-20
G12.22	Progressive bulbar palsy	0-20
G12.29	Other motor neuron disease	0-20
G12.8	Other spinal muscular atrophies and related syndromes	0-20
G12.9	Spinal muscular atrophy, unspecified	0-20
G24.1	Genetic torsion dystonia	0-64
G24.8	Other dystonia	0-64
G25.3	Myoclonus	0-5
G25.9	Extrapyramidal and movement disorder, unspecified	0-20
G31.81	Alpers disease	0-20
G31.82	Leigh's disease	0-20
G31.9	Degenerative disease of nervous system, unspecified	0-20
G32.81	Cerebellar ataxia in diseases classified elsewhere	0-20
G37.0	Diffuse sclerosis of central nervous system	0-64
G37.5	Concentric sclerosis (Balo) of central nervous system	0-64
G71.00	Muscular dystrophy, unspecified	0-64
G71.01	Duchenne or Becker muscular dystrophy	0-64
G71.02	Facioscapulohumeral muscular dystrophy	0-64
G71.09	Other specified muscular dystrophies	0-64
G71.11	Myotonic muscular dystrophy	0-64
G71.2	Congenital myopathies	0-64
G80.0	Spastic quadriplegic cerebral palsy	0-64
G80.1	Spastic diplegic cerebral palsy	0-20
G80.3	Athetoid cerebral palsy	0-64
G82.50	Quadriplegia, unspecified	0-64
G82.51	Quadriplegia, C1-C4 complete	0-64
G82.52	Quadriplegia, C1-C4 incomplete	0-64
G82.53	Quadriplegia, C5-C7 complete	0-64
G82.54	Quadriplegia, C5-C7 incomplete	0-64
G91.0	Communicating hydrocephalus	0-20

G91.1	Obstructive hydrocephalus	0-20
I67.5	Moyamoya disease	0-64
K91.2	Postsurgical malabsorption, not elsewhere classified	0-20
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	0-20
N03.2	Chronic nephritic syndrome w diffuse membranous glomrlneph	0-20
N03.3	Chronic neph syndrome w diffuse mesangial prolif glomrlneph	0-20
N03.4	Chronic neph syndrome w diffuse endocaplry prolif glomrlneph	0-20
N03.5	Chronic nephritic syndrome w diffuse mesangiocap glomrlneph	0-20
N03.6	Chronic nephritic syndrome with dense deposit disease	0-20
N03.7	Chronic nephritic syndrome w diffuse crescentic glomrlneph	0-20
N03.8	Chronic nephritic syndrome with other morphologic changes	0-20
N03.9	Chronic nephritic syndrome with unsp morphologic changes	0-20
N08	Glomerular disorders in diseases classified elsewhere	0-20
N18.1	Chronic kidney disease, stage 1	0-20
N18.2	Chronic kidney disease, stage 2 (mild)	0-20
N18.3	Chronic kidney disease, stage 3 (moderate)	0-20
N18.4	Chronic kidney disease, stage 4 (severe)	0-20
N18.5	Chronic kidney disease, stage 5	0-20
N18.6	End stage renal disease	0-20
N18.9	Chronic kidney disease, unspecified	0-20
Q01.9	Encephalocele, unspecified	0-20
Q02	Microcephaly	0-20
Q03.0	Malformations of aqueduct of Sylvius	0-20
Q03.1	Atresia of foramina of Magendie and Luschka	0-20
Q03.8	Other congenital hydrocephalus	0-20
Q03.9	Congenital hydrocephalus, unspecified	0-20
Q04.3	Other reduction deformities of brain	0-20
Q04.5	Megalencephaly	0-20
Q04.6	Congenital cerebral cysts	0-20
Q04.8	Other specified congenital malformations of brain	0-20
Q05.0	Cervical spina bifida with hydrocephalus	0-64
Q05.1	Thoracic spina bifida with hydrocephalus	0-64
Q05.2	Lumbar spina bifida with hydrocephalus	0-64
Q05.3	Sacral spina bifida with hydrocephalus	0-64
Q05.4	Unspecified spina bifida with hydrocephalus	0-64
Q05.5	Cervical spina bifida without hydrocephalus	0-64
Q05.6	Thoracic spina bifida without hydrocephalus	0-64
Q05.7	Lumbar spina bifida without hydrocephalus	0-64
Q05.8	Sacral spina bifida without hydrocephalus	0-64
Q05.9	Spina bifida, unspecified	0-64
Q06.0	Amyelia	0-64
Q06.1	Hypoplasia and dysplasia of spinal cord	0-64
Q06.2	Diastematomyelia	0-64
Q06.3	Other congenital cauda equina malformations	0-64
Q06.4	Hydromyelia	0-64

Q06.8	Other specified congenital malformations of spinal cord	0-64
Q07.01	Arnold-Chiari syndrome with spina bifida	0-64
Q07.02	Arnold-Chiari syndrome with hydrocephalus	0-64
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus	0-64
Q30.1	Agenesis and underdevelopment of nose, cleft or absent nose only	0-5
Q30.2	Fissured, notched and cleft nose, cleft or absent nose only	0-5
Q31.0	Web of larynx	0-20
Q31.8	Other congenital malformations of larynx, atresia or agenesis of larynx only	0-20
Q32.1	Other congenital malformations of trachea, atresia or agenesis of trachea only	0-20
Q32.4	Other congenital malformations of bronchus, atresia or agenesis of bronchus only	0-20
Q33.0	Congenital cystic lung	0-20
Q33.2	Sequestration of lung	0-20
Q33.3	Agenesis of lung	0-20
Q33.6	Congenital hypoplasia and dysplasia of lung	0-20
Q35.1	Cleft hard palate	0-20
Q35.3	Cleft soft palate	0-20
Q35.5	Cleft hard palate with cleft soft palate	0-20
Q35.9	Cleft palate, unspecified	0-20
Q37.0	Cleft hard palate with bilateral cleft lip	0-20
Q37.1	Cleft hard palate with unilateral cleft lip	0-20
Q37.2	Cleft soft palate with bilateral cleft lip	0-20
Q37.3	Cleft soft palate with unilateral cleft lip	0-20
Q37.4	Cleft hard and soft palate with bilateral cleft lip	0-20
Q37.5	Cleft hard and soft palate with unilateral cleft lip	0-20
Q37.8	Unspecified cleft palate with bilateral cleft lip	0-20
Q37.9	Unspecified cleft palate with unilateral cleft lip	0-20
Q39.0	Atresia of esophagus without fistula	0-3
Q39.1	Atresia of esophagus with tracheo-esophageal fistula	0-3
Q39.2	Congenital tracheo-esophageal fistula without atresia	0-3
Q39.3	Congenital stenosis and stricture of esophagus	0-3
Q39.4	Esophageal web	0-3
Q42.0	Congenital absence, atresia and stenosis of rectum with fistula	0-5
Q42.1	Congen absence, atresia and stenosis of rectum without fistula	0-5
Q42.2	Congenital absence, atresia and stenosis of anus with fistula	0-5
Q42.3	Congenital absence, atresia and stenosis of anus without fistula	0-5
Q42.8	Congenital absence, atresia and stenosis of other parts of large intestine	0-5
Q42.9	Congenital absence, atresia and stenosis of large intestine, part unspecified	0-5
Q43.1	Hirschsprung's disease	0-15
Q44.2	Atresia of bile ducts	0-20
Q44.3	Congenital stenosis and stricture of bile ducts	0-20
Q44.6	Cystic disease of liver	0-20
Q45.0	Agenesis, aplasia and hypoplasia of pancreas	0-5
Q45.1	Annular pancreas	0-5
Q45.3	Other congenital malformations of pancreas and pancreatic duct	0-5

Q45.8	Other specified congenital malformations of digestive system	0-10
Q60.1	Renal agenesis, bilateral	0-20
Q60.4	Renal hypoplasia, bilateral	0-20
Q60.6	Potter's syndrome, with bilateral renal agenesis only	0-20
Q61.02	Congenital multiple renal cysts, bilateral only	0-20
Q61.19	Other polycystic kidney, infantile type, bilateral only	0-20
Q61.2	Polycystic kidney, adult type, bilateral only	0-20
Q61.3	Polycystic kidney, unspecified, bilateral only	0-20
Q61.4	Renal dysplasia, bilateral only	0-20
Q61.5	Medullary cystic kidney, bilateral only	0-20
Q61.9	Cystic kidney disease, unspecified, bilateral only	0-20
Q64.10	Exstrophy of urinary bladder, unspecified	0-20
Q64.12	Cloacal extrophy of urinary bladder	0-20
Q64.19	Other exstrophy of urinary bladder	0-20
Q75.0	Craniosynostosis	0-20
Q75.1	Craniofacial dysostosis	0-20
Q75.2	Hypertelorism	0-20
Q75.4	Mandibulofacial dysostosis	0-20
Q75.5	Oculomandibular dysostosis	0-20
Q75.8	Other congenital malformations of skull and face bones	0-20
Q77.4	Achondroplasia	0-1
Q77.6	Chondroectodermal dysplasia	0-1
Q77.8	Other osteochondrodysplasia with defects of growth of tubular bones and spine	0-1
Q78.0	Osteogenesis imperfecta	0-20
Q78.1	Polyostotic fibrous dysplasia	0-1
Q78.2	Osteopetrosis	0-1
Q78.3	Progressive diaphyseal dysplasia	0-1
Q78.4	Enchondromatosis	0-1
Q78.6	Multiple congenital exostoses	0-1
Q78.8	Other specified osteochondrodysplasias	0-1
Q78.9	Osteochondrodysplasia, unspecified	0-1
Q79.0	Congenital diaphragmatic hernia	0-1
Q79.1	Other congenital malformations of diaphragm	0-1
Q79.2	Exomphalos	0-1
Q79.3	Gastroschisis	0-1
Q79.4	Prune belly syndrome	0-1
Q79.59	Other congenital malformations of abdominal wall	0-1
Q89.7	Multiple congenital malformations, not elsewhere classified	0-10
R75	Inconclusive laboratory evidence of HIV	0-12 months
Z21	Asymptomatic human immunodeficiency virus infection status	0-20
Z99.11	Dependence on respirator (ventilator) status	1-64
Z99.2	Dependence on renal dialysis	21-64

INSTRUCTIONS FOR COMPLETING THE REM INTAKE/REFERRAL FORM

PLEASE COMPLETE ALL REQUESTED INFORMATION

Page 1 –

Referral Source:
Referral source name, address, telephone number and fax number.

Patient Information:
Patient's first name, middle initial and last name. Patient's Medical Assistance (MA) number.
Patient's complete address, including apartment number, if applicable.
Patient's date of birth, telephone number(s), Sex, and Social Security Number.

Managed Care Organization (MCO) Information. This should include the name of the MCO, the name of a contact person and telephone number at the MCO, if known.

Patient Contact Information:
The person identified may be the patient (if an adult), the parent, guardian, caregiver, significant other etc. Please include the contact person's complete address, telephone number(s) and their relationship to the patient.

Referring Provider (Physicians, Nurse Practitioner, Physician Assistant) Information:
Provide the name of the referring provider. Include the provider's specialty, license number, and telephone number. The referring provider's signature is **required**. Include information about any consulting physicians with their specialties, telephone numbers, and license numbers, if known.

PAGE 2 –   Complete patient's name and date of birth at the top of page 2.

Clinical Information:
Provide the primary and secondary diagnoses including the ICD-10 codes. These are necessary to verify eligibility for REM enrollment.

Supporting Information:
This section will require specific information pertaining to each REM diagnosis. The history and physical sections should be completed. Please refer to the guidelines listed on the REM disease list for the recommended medical documentation for each REM eligible diagnosis. Please contact the REM Intake Unit at 1-800-565-8190 if you have any questions.

PLEASE NOTE:
A physician's signature is required at the bottom of page 2. Please fax this completed form and all supporting clinical information to the REM Intake Unit at 410-333-5426.

Or mail to:
Maryland Department of Health & Mental Hygiene
REM Intake Unit
201 W. Preston Street, Room 210
Baltimore, Maryland 21201-2399
                For questions, please call the REM Intake Unit at 1-800-565-8190.
                                        Packet revised 10/07/2015

Intake & Referral Form

Rare and Expensive Case Management

Questions - Call 1-800-565-8190

Fax (410) 333-5426

Mail or Fax To:

REM Intake Unit
Department of Health & Mental Hygiene (DHMH)
201 W. Preston Street, Room 210
Baltimore, Maryland 21201

Referral Source: _____

Address: _____

Phone ( )	Fax ( )

DHMH USE ONLY		
CM Agency:		
Date Assigned:		☐ Incomplete
Screener/Date		☐ Complete
		Date Received:
County		
Date File Complete:		☐ Approved
		☐ Denied
		Decision Date:

PATIENT INFORMATION

Patient Name				MA #:	
Address				Home Phone ( )	
Apt. #		DOB:		Work Phone ( )	
City	State	Zip	Sex: **M F**	SSN:	

MCO	Contact Person
	Phone ( )

Patient Contact		Contact Phone ( )	
Address		Relationship to Patient	
Apt. #	City	State	Zip Code

Referring Physician	Signature:	Date:
Name	Phone ( )	
Specialty	License #	
PCP		
Name	Phone ( )	
Specialty	License #	
Consulting Physician		
Name	Phone ( )	
Specialty	License #	

REM Intake & Referral Form

Patient Name: _____   **DOB:** _____

CLINICAL INFORMATION			
Primary Diagnosis		**Secondary Diagnosis**	
ICD-10 Code		ICD-10 Code	
	1		1
	2		2
	3		3
	4		4

SUPPORTING INFORMATION (ATTACH COPIES)
History
Physical
Laboratory/Pathology
Radiology
Consultations
Comments

MD Signature	Date

RARE AND EXPENSIVE DISEASE LIST
OCTOBER 1, 2015

***USE WITH REVISED REM ICD 10 DISEASE LIST TO IDENTIFY THE GUIDELINES REQUIRED TO CONFIRM A REM DIAGNOSIS

Submit supporting documentation as required in the Guidelines box for the selected REM qualifying ICD 10 code (s).

#1   History and Physical completed within the past 12 months

#2   Specialist Consult note or report confirming diagnosis:

A. Cardiology		**J.** Ophthalmology
B. Ears, Nose, Throat		**K**. Orthopedic**s**
C. Endocrinology		**L.** Physiatrist/PMR
D. Gastroenterology		**M**. Plastic Surgery
E. Genetics		**N.** Pulmonologist
F. Hematology		**O.** Surgery
G. Pediatric Nephrology/Adult Nephrology		**P.** Urology
H. Neurology/Neurosurgery		
I. Nutrition		

#3   Laboratory values confirming REM qualifying diagnosis

#4   Imaging Studies confirming diagnosis, for example:
  A.   CT Scan
  B.   MRI/MRA
  C.   Ultra-sound
  D.   X-rays

Attachment 2

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

☐ **Well child exam only (see attached physical exam form)**

SBHC Name & Address: **SBHC Provider Number:** **Contact Name:** **Telephone:** **Fax:**	**MCO Name & Address:** **Contact Name:** **Telephone:** **Fax:** **Date Faxed:**

Student Name:
DOB:
MA Number:
SS Number:
	Date of Visit:
	
	Type of Visit:
	     ☐ **Acute/Urgent**
	     ☐ **Follow Up**
	     ☐ **Health Maintenance**
		ICD-10 Codes

Provider Name/Title:		**CPT Codes**
T: Hgt: Rapid Strep Test: - P: Wgt: Hgb: RR: BMI: BGL: BP: U/A: PF: PaO2:	**Drug Allergy:** ☐ **NKDA**	
	Current Medications:	**Immunization review:** ☐ **UTD** **Given today:** **Needs:**

Age: **Chief Complaint:**
HPI:

Past Medical History: ☐ **Unremarkable**   ☐ **See health history**   ☐ **Pertinent:**

Physical Findings:

General: ☐ Alert/NAD
☐ Pertinent:

Head: ☐ Normal
☐ Pertinent:

Ears: ☐ TMs: pearly, + landmarks , + light reflex
          ☐ Cerumen removed curette/lavage
☐ Pertinent**:**

Eyes: ☐ PERRLA, sclerae clear, no discharge/crusting
☐ Pertinent:

Nose: ☐ Turbinates: pink, without swelling
☐ Pertinent:

Mouth: ☐ Pharynx without erythema, swelling, or exudate
          ☐ Normal dentition without caries
☐ Pertinent:

Neck: ☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: ☐ No lymphadenopathy
☐ Pertinent:

Cardiac: ☐ RRR, normal S1 S2, no murmur
☐ Pertinent:

Lungs: ☐ CTA bilaterally, no retractions, wheezes, rales, ronchi
☐ Pertinent:

Abdomen: ☐ Soft, non-tender, no HSM, no masses,
          ☐ Bowel sounds present
☐ Pertinent:

Genitalia: ☐ Normal female/normal male   Tanner Stage
☐ Pertinent:

Extremities: ☐ FROM
☐ Pertinent:

Neurologic: ☐ Grossly intact
☐ Pertinent:

Skin: ☐ Intact, no rashes
☐ Pertinent:

ASSESSMENT: **PLAN:**   **Rx Ordered:**

Labs Ordered:

Radiology Services Ordered:

PCP F/U Required: ☐ Yes   ☐ No

Provider Signature: _____

DHMH 2015   **For MCO formulary info, find MCO website at:** https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/Home.aspx

Attachment 3

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	http://www.alleganyhealthdept.com/
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	http://www.aahealth.org/
Baltimore City	410-396-4398	410-396-7633	410-640-5000	http://health.baltimorecity.gov/
Baltimore County	410-887-2243	410-887-2828	410-887-8741	http://www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	http://www.calverthealth.org/
Caroline	410-479-8000	410-479-8014	410-479-8189	https://health.maryland.gov/carolinecounty/Pages/NewHome.aspx
Carroll	410-876-2152	410-876-4813	410-876-4941	http://cchd.maryland.gov/
Cecil	410-996-5550	410-996-5171	410-996-5130	http://www.cecilcountyhealth.org
Charles	301-609-6900	301-609-6923	301-609-6760	http://www.charlescountyhealth.org/
Dorchester	410-228-3223	410-901-2426	410-901-8167	http://www.dorchesterhealth.org/
Frederick	301-600-1029	301-600-3124	301-600-3124	http://health.frederickcountymd.gov/
Garrett	301-334-7777	301-334-7727	301-334-7771	http://garretthealth.org/
Harford	410-838-1500	410-638-1671	410-942-7999	http://harfordcountyhealth.com/
Howard	410-313-6300	877-312-6571	410-313-7323	https://http://www.howardcountymd.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	http://kenthd.org/
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1635	http://www.montgomerycountymd.gov/hhs/
Prince George's	301-883-7879	301-856-9555	301-856-9550	http://www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4456	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-4330	http://www.smchd.org/
Somerset	443-523-1700	443-523-1722	443-523-1758	http://somersethealth.org/
Talbot	410-819-5600	410-819-5609	410-819-5600	https://health.maryland.gov/talbotcounty/Pages/home.aspx

Washington	240-313-3200	240-313-3264	240-313-32229	https://health.maryland.gov/washhealth/ Pages/home.aspx
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	https://www.wicomicohealth.org/
Worcester	410-632-1100	410-632-0092	410-629-0614	http://www.worcesterhealth.org/

Attachment 4

<table>
<tr><td>

Date: /   /
To:
Attention:
Address:
City/State/Zip:
Phone:

</td><td>

**HealthChoice
LOCAL HEALTH SERVICES
REQUEST FORM**

</td></tr>
</table>

Client Information

Client Name: Address: City/State/Zip: Phone: County: DOB: / / SS#: - - Sex: ☐M ☐F Hispanic: ☐Y ☐N MA#: Private Ins.: ☐ No ☐Yes Marital Status: ☐Single ☐Married ☐Unknown If Interpreter is needed specific language:	Race: ☐African-American/Black ☐Alaskan Native ☐American Native ☐Asian ☐Native Hawaiian ☐Pacific Islander ☐White ☐More than one race ☐Unknown Caregiver/Emergency Contact: Relationship: Phone:

FOLLOW-UP FOR: (Check all that apply)	RELATED TO: (Check all that apply)
☐Child under 2 years of age ☐Child 2 – 21 years of age ☐Child with special health care needs ☐ Pregnant EDD: ____ / ____ / ____ ☐Adults with disability(mental, physical, or developmental) ☐Substance use care needed ☐Homeless (at-risk)	☐Missed appointments: ___ #missed ☐Adherence to plan of care ☐Immunization delay ☐Preventable hospitalization ☐Transportation ☐Other:

Diagnosis:

Comments:

MCO:	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) _____ # Face to Face _____	☐Unable to Locate ☐Contact Date: / / ☐Advised ☐Refused
Comments:	
Contact Person: Phone: Fax:	Provider Name: Provider Phone:

Local Health Department (County)	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) _____ # Face to Face _____	☐No Action (returned) Reason for return:
Contact Person: Contact Phone:	Disposition: ☐Contact Complete: Date: / / ☐Unable to Locate: Date: / / ☐Referred to: Date: / /
Comments:	

DHMH 4582 8/14

Attachment 5

Maryland Prenatal Risk Assessment- MDH 4850
(Refer to the Instructions at the bottom of this document before completing this form)

Provider Demographic Information:
Date of Initial Prenatal Visit/ Form Completed: _____/_____/_____
Provider NPI#: _____ Site NPI# _____
Provider Name: _____ Provider Phone Number: _____-_____-_____

Patient Demographic Information:
Patient Last Name:_____First Name:_____ Middle I:_____
DOB: _____/_____/_____ Preferred Pronouns: _____
Social Security Number: _____-_____-_____ Medical Assistance Number (MA): _____
Current Address: Street _____City_____County _____State_____ Zip Code _____
Best Contact Phone Number: _____-_____-_____ Email: _____
Emergency Contact Name: _____ Contact Phone Number:_____-_____-_____
Communication Barrier: Yes _____(Requires an Interpreter Y/N) No _____ Primary Language _____

Insurance Status (at time of prenatal visit):

Uninsured: Y_____N_____	FFS: Y _____N _____	Applied for Maryland MA: Y_____N_____ Date: _____/_____/_____
Maryland Medicaid: Y _____N_____		MCO: _____

Demographics:

Biologic Sex	Male _____Female_____	Other: _____	
Gender Identity	Cisgender: Male _____Female_____	Other: (Patient's own definition) _____	
Race (check all that apply)	Black or African American _____	Asian _____	American Native _____
	Hispanic _____	Native Hawaiian/Pacific Islander ____	Alaska Native _____
	Non Hispanic White_____	Multiracial_____	Unknown_____
Educational Level:	Highest Grade Completed _____	Currently in School: Yes _____ No_____	GED: Yes _____No_____
Marital Status:	Married _____	Unmarried _____	Unknown _____
	Separated _____	Divorced _____	

Obstetric History Gravida_____Para _____:

#Full Term Births		#Preterm Births		#Ectopic Pregnancies	
#Spontanous Abortions		#Theraputic Abortions		#Living Children	

Entry to Prenatal Care:

OB Date of Initial Visit	____/__/____	Trimester of 1st Prenatal visit	_____1st _____2nd _____3rd
Previous OB Care	____/__/____	LMP ___/___/_____	EDC ___/___/_____

Risk Factor Assessment:

Psychosocial Risks (Check all that apply)

Mental/Behavioral Health[1]	Overwhelming Anxiety/Stress: Y_____N_____ Poor Coping Skills: Y ____N_____ Depression: (Active Diagnosis : Y ____N___, Past Hx: Y _____N_____) Partner Dissatisfaction: Y___N_____ Intimate Partner/Family Violence/Abuse: Y_____N_____ Developmental Disability: Y_____N_____
Behavioral Health Admissions[2]	Recent Psychiatric Inpatient Admission within <1 year: Y_____N_____ Admission Diagnosis: _____
Substance Misuse[2]	Drugs and/or Opioid Misuse/Addiction: Y _____N_____ Drug: _____ Currently in SUD treatment: Methadone_____Subutex _____ Recent SUD related Inpatient Admission. within <1 year: Y_____N_____ Exchanging sex for drugs: Y_____N_____ Nicotine/Tobacco/Vaping use: Y_____N_____ Amount:_____ Alcohol: Y _____N_____Amount _____/day
Financial Insecurity[3]	Currently Unemployed:. Y__N _____ Temporary Assistance for Needy Families (TANF) eligibility: Y____N _____
Social Support/Network[4]	Identified lack of Friends/Family Social Support Network: Y_____N_____ Housing Insecurity/Homelessness: Y_____N_____ Lack of Transportation: Y_____N_____ Child Care Issues: Y_____N _____ Recent incarceration/Partner currently incarcerated: Y_____N _____
Nutrition	Food Insecurity/Poor Nutrition: Y_____N_____
Exercise//Self Care	Lack of regular exercise (30min/day for at least 3x/wk): Y_____N_____

Medical Risks (Check all that apply)

Maternal Age	Age< or = 16 _____ Age> or = 35 _____
Maternal BMI	BMI<18.5 _____ or BMI>30 _____
Sexually Transmitted Infection - STI. (GC/Chlamydia/HIV/Hep B/C or Syphilis)	Current/Recently Treated STI: STI Name: _____ STI screening (including Syphilis) completed for current Pregnancy: Y ___N__ Past STI Hx: (Syphilis) _____(Herpes)_____
Chronic Disease	Asthma: Y_____N_____ Inhaler Rx: Y___N Diabetes Y__ N___: If yes then Treatment Medication: _____ Chronic HTN/Heart Disease: Y__N___ Sickle Cell Disease: Y____N_____ Sickle Cell Trait: Y_____N_____ Anemia - HCT<33 or HGB <11: Y___ N ___ Lab Result _____ AutoImmune Disorder: Y_____N_____ If yes please name: _____ H/O - Thrombophilias/DVT: If yes please describe: _____

Dental Care	Last Dental visit >1 year. Y_____N_____

Pregnancy Risk Factors (Check all that apply)

Identified obstetric risks	Patient's First Pregnancy: Yes____No____ Covid Vaccinated: Yes _____No_____ Covid Booster Current: Yes _____No _____ Short Interval Pregnancy <9 Months from last birth: Yes_____No_____ Late Entry into Care >14 week: Y___N____ Previous H/O Preterm Labor/Birth: Y_____N____ H/O Previous Gestational Diabetes: Y___N____ Current multiple gestation pregnancy: Y_____N_____ H/O previous LBW Baby: Y_____N_____ H/O previous Fetal Death In Utero >20 weeks: Y _____N_____ Previous Pregnancy affected with Preeclampsia/Eclampsia/HELLP Syndrome: Y ____N_____ H/O Cervical Incompetence: Y _____N____ H/O Previous infant affected with congenital defect: Y ____ N____Define: _____

DEFINITIONS (To help complete Risk Assessment)

[1]Mental/Behavioral Health	Concern for the need of BH Services.
[1]Intimate Partner/Family Violence/Abuse	Physical, psychological abuse or violence within the patient's environment.
[1]Exposure to long-term stress	Partner-related, financial, personal, emotional.
[2]Substance Misuse	• Concern for use of illegal substances within the past 6 months. • At "risk-drinker" as determined by a screening tool such as T-ACE, CAGE, or AUDIT.
[3]Financial Insecurity	Example: Unemployed > 3months. Involved in exchanging sex for drugs.
[4]Lack of social/emotional support	Absence of support system I.e. family/friends. Feeling isolated.
Family History/Genetic risk.	At risk for a genetic or hereditary disorder. Known genetic carrier. H/O congenital anomalies.
Communication barrier	In need of an interpreter.
Dental Care	Last Dental Visit > 1year.
Prior Preterm birth	H/O of preterm birth (prior to the 37th gestational age).
Prior LBW birth	Low birth weight birth (under 2,500 grams).

**Maryland Prenatal Risk Assessment Form
(Instructions for use)**

<u>Purpose of Form</u>: Identifies pregnant women who may benefit from local health department Administrative Care Coordination (ACCU) services and serves as the referral mechanism. ACCU services complement medical care and may be provided by nurses, community health and outreach workers and may include education about Medicaid benefits, reinforcement of the medical plan of care, resource linkage and other related services.

<u>Instructions</u>: On the initial visit the provider/staff will complete the demographic and assessment sections for pregnant women enrolled in Medicaid at registration and those applying for Medicaid.

- Enter both the provider and site/facility NPI numbers.
- Print clearly; use black pen for all sections.
- If the client does not have a social security number, indicate zeroes.
- Indicate the person completing the form.
- Review for completeness and accuracy.

<u>Faxing and Handling Instructions</u>: **Fax the MPRA to the local health department in the client's county of residence**. To reorder forms call the local ACCU.

Mailing Address (client resides)	Phone Number
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-5094 Fax: 301-777-2401
Anne Arundel County ACCU 3 Harry S. Truman Parkway, HD8 Annapolis, MD 21401	410-222-7541 Fax: 410-222-4150
Baltimore City ACCU Healthcare Access Maryland 1 N. Charles St., #900 Baltimore, MD 21201	410-640-5000 Fax: 1-888-657-8712
Baltimore County ACCU 6401 York Rd., 3rd Floor Baltimore, MD 21212	410-887-8741 Fax: 410-828-8346
Calvert County ACCU P.O. Box 980 Prince Frederick, MD 20678	410-535-5400 Fax: 1-833-662-7942
Caroline County ACCU 403 S. 7th St. Denton, MD 21629	410-479-8189 Fax: 410-479-4871
Carroll County ACCU 290 S. Center St. Westminster, MD 21158-0845	410-876-4941 Fax: 410-876-4949 Email: cchd.accu@maryland.gov
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5130 Fax: 410-996-0072
Charles County ACCU 4545 Crain Highway White Plains, MD 20695	301-609-6760 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-901-8167 Fax: 410-228-8976
Frederick County ACCU 350 Montevue Lane Frederick, MD 21702	301-600-3124 Fax: 301-600-3302
Garrett County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7770 Fax: 301-334-7771

Harford County ACCU 2015 Pulaski Highway, Suite E Havre De Grace, MD 21708	410-942-7999 Fax: 443-502-8975
Howard County ACCU 8930 Stanford Blvd. Columbia, MD 21045	410-313-7323 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7035 Fax: 1-844-222-7105
Montgomery County ACCU 1401 Rockville Pike, Suite 2400 Rockville, MD 20852	240-777-1635 Fax: 240-777-4645
Prince George's County ACCU 9314 Piscataway Rd. Clinton, MD 20735	301-856-9550 Fax: 301-856-9607
Queen Anne's County ACCU 206 N. Commerce Street Centreville, MD 21617	443-262-4456 Fax: 443-262-9357
St. Mary's County ACCU 21580 Peabody St. Leonardtown, MD 20650	301-475-4330 Fax: 301-309-4117
Somerset County ACCU 8928 Sign Post Road Westover, MD 21871	443-523-1758 Fax: 410-651-2572
Talbot County ACCU 100 S. Hanson Street Easton, MD 21601	410-819-5600 Fax: 410-819-5683
Washington County ACCU 1302 Pennsylvania Avenue Hagerstown, MD 21742	240-313-3229 Fax: 240-313-3222
Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6964
Worcester County ACCU 9730 Healthway Drive Berlin, MD 21811	410-629-0164 Fax: 410-629-0185

Revised 10.4.2022

Attachment 6

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) | 1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED — Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)

CITY STATE | 8. PATIENT STATUS — Single Married Other — Employed Full-Time Student Part-Time Student | CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( ) | ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. AUTO ACCIDENT? YES NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 2. 3. 4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED _____ DATE _____
32. SERVICE FACILITY LOCATION INFORMATION — a. NPI b.
33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

NUCC Instruction Manual available at: www.nucc.org | PLEASE PRINT OR TYPE | APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bill.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Attachment 7

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.

5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.

6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.

9. For TRICARE Purposes:

(a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically and appropriate for the health of the patient;

(b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

(c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;

(d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;

(e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

(f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

(g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and

(h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care a participating provider.

1		2		3a PAT. CNTL #		4 TYPE OF BILL
				b. MED. REC. #		
				5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a		9 PATIENT ADDRESS	a				
b			b			c	d	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37

38			39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
		a			
		b			
		c			
		d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23	*PAGE ____ OF ____*	*CREATION DATE*		**TOTALS** ➡			23

50 PAYER NAME		51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57 OTHER PRV ID	A
B								B
C								C

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A					A
B					B
C					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI QUAL
				LAST FIRST
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI QUAL
				LAST FIRST
80 REMARKS	81CC a		78 OTHER NPI QUAL
	b		LAST FIRST
	c		79 OTHER NPI QUAL
	d		LAST FIRST

UB-04 CMS-1450   APPROVED OMB NO.   THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee
LIC9213257

Attachment 8

Provider Reportable Communicable Diseases & Laboratory Reportable Communicable Diseases

The diseases or conditions reportable by a medical laboratory director are:

Amebiasis

Anaplasmosis

Animal Bites

Anthrax

Arbovirus infection (all types)

Babesiosis

Botulism

Brucellosis

Campylobacter infection

Chancroid

Chlamydia infection

Cholera

Coccidioidomycosis

Creutzfeldt-Jakob Disease

Cryptosporidiosis

Cyclosporiasis

Dengue fever

Diphtheria

Ehrlichiosis

Encephalitis

Epsilon toxin of Clostridium perfringens

Escherichia coli 0157:H7 infection

Giardiasis

Glanders

Gonococcal infection

Haemophilus influenzae, invasive disease

Hansen disease (leprosy)

Hantavirus infection

Harmful algal bloom related illness

Hemolytic uremic syndrome, post-diarrheal

Hepatitis, viral, types A, B, C, Delta, non-ABC, E,F,G, undetermined

Human immunodeficiency virus infection

Influenza-associated pediatric mortality

Isosporiasis

Kawasaki Syndrome

Legionellosis

Leptospirosis

Listeriosis

Lyme disease

Malaria

Measles (rubeola)

Melioidosis

Meningococcal invasive disease

Meningitis, infectious Microsporidiosis

Mumps (infectious parotitis)

Mycobacteriosis, other than tuberculosis and leprosy

Novel influenza A virus infection

Pertussis

Pertussis vaccine adverse reactions

Pesticide related illness

Plague

Pneumonia in a healthcare worker resulting in hospitalization

Poliomyelitis

Psittacosis

Q fever

Rabies

Ricin toxin

Rocky Mountain spotted fever

Rubella (German measles) and congenital rubella syndrome

Salmonellosis (nontyphoid fever types)

Septicemia in newborns

Severe acute respiratory syndrome (SARS)

Shiga-like toxin producing enteric bacterial infections

Shigellosis

Smallpox and other orthopox viruses

Staphylococcal enterotoxin

Streptococcal invasive disease, group A

Streptococcal invasive disease, group B

Streptococcus pneumoniae, invasive disease

Syphilis

Tetanus

Trichinosis

Tuberculosis and suspected Tuberculosis

Tularemia

Typhoid fever (case or carrier, or both, of Salmonella typhi)

Vancomycin Intermediate Staphylococcus aureus (VISA)

Vancomycin-Resistant Staphylococcus-aureus (VRSA)

Varicella (chickenpox) fatal cases only

Vibriosis, Non-Cholera

Viral hemorrhagic fevers (all types)

Yellow fever

Yersiniosis

Attachment 9

Schedule of Preventive Screenings

Physical Exam				
	18-25 years	26-39 years	40-49 years	50+ years
Health Maintenance Exam	Every 5 Years	Every 5 Years	Every 2-3 Years	Every 1-2 Years
Height Weight, BMI, BP	Every 2 Years	Every 2-3 Years	Every 2-3 Years	Every 1-2 Years
Clinical Breast Exam (CBE)	Every 1-3 Years	Every 1-3 Years	Every 1-2 Years	Annually
Self-Exams breast, testicles	Monthly	Monthly	Monthly	Monthly
Prostate Cancer			After 40, every 3-4 years	Annually
Screening				
Cervical Smear w/ Pelvic Exam	Every 1-3 Years	Every 1-3 Years	Every 1-3 Years	Every 1-3 Years
Chlamydia Screen	Every 6 Months	Annually	Annually	Annually
Mammography		Baseline	Every 1-2 years	Annually
Colorectal Cancer-Fecal Occult Blood				Annually

Attachment 10

Maryland Healthy Kids Preventive Health Schedule

Age groups: Birth–9 mo = Infancy (months); 12–48 = Early Childhood (months); 5–10 = Late Childhood (yrs); 11–19/20 = Adolescence (yrs).

Components	Birth	3-5 d	1	2	4	6	9	12	15	18	24	30	36	48	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19/20
Health History and Development																													
Medical and family history/update	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peri-natal history	X	X																											
Psycho-social/environmental assessment/update	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Surveillance (Subjective)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Screening (Standard Tools)[1]			↓	↓	↓	↓	X	↓	↓	X	↓	X	↓																
Autism Screening										X	X																		
Mental health/behavioral assessment															X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Substance abuse assessment																					X	X	X	X	X	X	X	X	X
Depression Screening																						X	X	X	X	X	X	X	X
Physical Exam																													
Systems exam	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vision/hearing assessments[2]	O[2]	S	S	S	S	S	S	S	S	S	S	S	S/O	S/O	S/O	S	S/O	S/O	S	S/O	S	S/O	S	S	S/O	S/O	S	S	S
Oral/dentition assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Measurements and graphing: Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X	X	X	X	X																		
BMI											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure[3]													X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Risk Assessments by Questionnaire																													
Maternal Depression Screening			X	X	X	X																							
Lead assessment by questionnaire						X	X	X		X	X	X	X	X	X	X													
Tuberculosis *			↓			↓		↓			↓																		
Heart disease/cholesterol *											↓		↓	↓															
Sexually transmitted infections (STI) *																					↓	↓	↓	↓	↓	↓	↓	↓	↓
Anemia *									↓	↓	↓										↓	↓	↓	↓	↓	↓	↓	↓	↓
Laboratory Tests																													
Newborn Metabolic Screening		X	X																										
Blood lead Test								X			X		↓	↓	↓	↓													
Anemia Hgb/Hct								X	↓	↓	↓	↓	↓	↓											↓		↓		↓
Dyslipidemia Test											↓								X	X							↓	↓	
HIV Test																									X	X	X	X	X
Health Education																													
Age-appropriate education/guidance	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counsel/referral for identified problems	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental education/referral						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fluoride Varnish Program[4]							X	X	X	X	X	X	X	↓	↓	↓													
Immunizations																													
Vaccines given per schedule	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
History of immunizations	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Scheduled return visit	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Key: X Recommended; → Recommended if not previously done; S Subjective by history/observation; O Objective by standardized testing; * Counseling/testing recommended when positive

The Schedule reflects minimum standards required for all Maryland Medicaid recipients from birth to 21 years of age. The Maryland Healthy Kids Program requires yearly preventive care visits between ages 3 years through 20 years. [1]Refer to AAP 2006 Policy Statement referenced in the Healthy Kids Program Manual. [2]Screening required using standardized tools. [3]Newborn Hearing Screen follow-up recommended for abnormal results. [3]Blood Pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years. [4]The fluoride varnish may be administered by either a primary care provider or a dentist.

http://mmcp.dhmh.maryland.gov/epsdt

Healthy Kids Program — Effective 01/01/2018