Introduction to the Provider Manual

HealthChoice is Maryland’s Medicaid managed care program. Overseen by the Maryland Department of Health and Mental Hygiene (DHMH), the HealthChoice program serves more than 500,000 individuals. These individuals are enrolled in one of the participating managed care organizations (MCOs). Each MCO has policies and procedures that providers who deliver services to recipients must adhere to. Any questions a provider has about the policies of individual MCOs should be addressed by the provider information supplied by the MCO it participates in.

While each HealthChoice MCO has its own policies and procedures, many program elements apply to all providers, regardless of the MCO. The purpose of this manual is to explain those elements and be a useful reference for providers who participate in the HealthChoice program. The manual is divided into six sections:

Section I - General Information. This section provides general descriptive information on the HealthChoice program including, but not limited to, program eligibility, MCO reimbursement policies, continuity of care and transportation.

Section II - Provider Responsibilities. This section discusses expectations of all providers, regardless of MCO affiliation.

Section III - HealthChoice Benefits and Services. This section provides a listing of the benefits that are and are not the responsibility of all MCOs that participate in HealthChoice. This section briefly outlines some of the optional benefits that UnitedHealthcare Community Plan may provide. This section also identifies benefit limitations and services that are not the responsibility of UnitedHealthcare Community Plan.

Section IV - Specialty Mental Health Services. Individuals eligible for the HealthChoice program who are receiving specialty mental health services may receive some or all of their services outside of UnitedHealthcare Community Plan network. This section details the services.

Section V - Rare and Expensive Case Management (REM). Enrollees with certain diagnoses may dis-enroll from UnitedHealthcare Community Plan and receive their services through the REM program. This section details the REM program.

Section VI - DHMH Quality Improvement Program and MCO Oversight Activities. DHMH conducts numerous quality improvement activities for the HealthChoice program. This section reviews DHMH’s quality improvement activities. These activities are separate from quality improvement activities that UnitedHealthcare Community Plan may engage in.
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The Maryland Healthchoice Program

HealthChoice is the name of the Maryland’s statewide mandatory managed care program. The HealthChoice Program provides health care to most Medicaid participants. Eligible Medicaid participants enroll in a Managed Care Organization (MCO) of their choice and select a primary care provider (PCP) to oversee their medical care.

Healthchoice Eligibility

While most Medicaid recipients are eligible to participate in HealthChoice, due to certain circumstances or conditions of Medicaid eligibility, some are not eligible to be enrolled in an MCO. These recipients include:

- Individuals who receive Medicare,
- Individuals who are 65 years or older,
- Individuals who are eligible for Medicaid under spend down,
- Medicaid recipients who have been or expected to be continuously institutionalized for more than 30 successive days in a long term care facility or in an institution for mental diseases (IMD),
- Individuals institutionalized in an intermediate care facility for mentally retarded persons (ICF-MR),
- Recipients enrolled in the Model Waiver, and
- Recipients enrolled in limited coverage categories, such as women who receive family planning services through the Family Planning Program.

All Medicaid recipients 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 Section V.

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

Member Rights and Responsibilities

Members of UnitedHealthcare Community have the right to:

- Be treated with respect, dignity and privacy.
- Receive information, including information on treatment options and alternatives 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.
- Receive information about the Plan, its services, practitioners, providers and members’ rights and responsibilities.
- An open discussion about medically necessary treatment options for health conditions, regardless of cost or benefit coverage.
- Make recommendations regarding the health plan’s member rights and responsibilities policy.
- Request and receive a copy of their medical records and request that they be amended or corrected as allowed.
- Exercise their rights and to know that the exercise of those rights will not adversely affect the way UnitedHealthcare Community Plan or our providers treat you.
- File appeals and grievances with UnitedHealthcare
- File appeals and grievances with the state.
- State fair hearings.
• Request that ongoing benefits be continued during an appeal or state fair hearing; however, they may have to pay for the continued benefits, if our decision is upheld in the appeal or hearing.

• Receive a second opinion from another doctor in the UnitedHealthcare Community Plan provider network if the member doesn’t agree with your doctor’s opinion about the services that you need. Contact UnitedHealthcare Community Plan’s Member Services at 800-318-8821 for help with this.

• Receive other information about us such as how we are managed. You may request this information by calling UnitedHealthcare Community Plan’s Member Services at 800-318-8821.

As a UnitedHealthcare Community Plan member, it is important to:

• Cooperate with those providing you with healthcare services.

• Provide all information as needed to the professional staff caring for them.

• Follow instructions and guidelines given by those providing health care services.

• Call after enrollment to make an appointment for a health assessment.

• Call for appointments to minimize waiting time.

• Inform the doctor’s office at least 48 hours in advance if you need to cancel your appointment.

• Call Member Services if a member is not sure if they should call your doctor or go to the emergency room.

• If problems arise concerning the medical care you received, make their feelings known to UnitedHealthcare. Every effort will be made to solve your problem.

• Learn more about keeping well and better managing any health care problems by taking advantage of health education services and classes available to the member.

• Understand health problems and participate in developing mutually agreed upon treatment goals.

• Report any other health insurance coverage to their doctor or UnitedHealthcare Community Plan.

• Report any public health problems such as tuberculosis to their doctor.

Provider Credentialing and Recredentialing

UnitedHealthcare Community Plan’s credentialing and recredentialing program is a peer-review process of assessing and validating applicable criteria and qualifications of licensed practitioners and facilities prior to and maintaining participation in the UnitedHealthcare Community Plan network.

During the UnitedHealthcare Community Plan credentialing and recredentialing process, practitioners have the right to:

1. Review information submitted to support their credentialing application

2. Correct erroneous information.

3. Receive the status on their credentialing or recredentialing application upon request.

The UnitedHealthcare Community Plan 2011-2012 Credentialing Plan is available in the Policies and Protocols section of the practitioner online portal at UnitedHealthcareOnline.com

Provider Reimbursement

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

Reimbursement for hospitals and other applicable 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 recipient’s enrollment in our MCO. We are, however, responsible for reimbursement to providers for professional services rendered during the remaining days of the admission. Please refer to UHCCommunityPlan.com > Healthcare Professionals > Reimbursement Policy for additional information.

Self-Referred and Emergency Services

UnitedHealthcare Community Plan will reimburse out-of-plan providers for the following services:

- Emergency services provided in a hospital emergency facility;
- Family planning services except sterilizations;
- 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. A school based health center reporting form can be found in Section VI;
- Pregnancy-related services when an enrollee

has begun receiving services from an out-of-plan provider prior to enrolling in an MCO;

- Initial medical examination for children in-state custody;
- Annual Diagnostic and Evaluation services for recipients 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; and
- An initial assessment for substance abuse.

- Substance-abuse services such as individual and group counseling, detoxification and inpatient care when provided by an ADAA certified provider and ASAM criteria is met.

Self-Referred Services for Children With Special Healthcare Needs

Children with special health care needs may self-refer to providers outside of the UnitedHealthcare Community Plan network under certain conditions. 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 Enrollee: 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 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 Enrollee:** 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 provider. We are obliged to grant the enrollee’s request unless we have a local in-network specialty 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, enrollees have an appeal right, regardless of whether they are a new or established enrollee. Pending the outcome of an appeal, we may reimburse for services provided.

**Primary Care Provider (PCP) Contract Terminations**

If you are a PCP and we terminate your contract for any of the following reasons, the enrollees 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’s reduction of 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.

- For additional information regarding obligations upon termination, please reference the Term & Termination section of your provider agreement.

**Continuity of Care**

As part of the HealthChoice Program design, we are responsible for providing ongoing treatments and patient care to new recipients until an initial evaluation is completed and we develop a new plan of care.

The following steps are to be taken to ensure that enrollees continue to receive necessary health services at the time of enrollment into UnitedHealthcare Community Plan:

- Appropriate service referrals to specialty care providers are to be provided in a timely manner.

- Authorization for ongoing specialty services will not be delayed while members await their initial PCP visit and comprehensive assessment. Services comparable to those that the member was receiving upon enrollment into UnitedHealthcare Community Plan are to be continued during this transition period.

- If we determine that a reduction or termination is warranted after it has been initially approved by UnitedHealthcare Community Plan, we will notify the recipient of this change at least 10 days before it is implemented. This notification will tell the member that he/she has the right to formally appeal to the MCO or to the department by calling the MCO or the Enrollee Help Line at 800-284-4510. In addition, the notice will explain that if the member files an appeal within 10 days of our notification, and requests to continue receiving the services, then we will continue to provide these services until the appeal is resolved. You will receive a copy of this notification.

- In cases of terminations, provider must cooperate with the MCO to develop a transition of care program, for patients in a course of treatment, including point of contact and phone number.

**Specialty Referrals**

- We will maintain a complete network of adult and pediatric providers adequate to deliver the
full scope of benefits as required by COMAR 10.09.66 and 10.09.67.

• If a specialty provider cannot be identified contact us at 877-842-3210 or the Provider Hotline at 800-766-8692 for assistance.

**Transportation**

You may contact the local health department (LHD) to assist enrollees in accessing non-emergency transportation services. UnitedHealthcare Community Plan will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD.

We will provide non-emergency transportation necessary for our enrollees to access a covered service if we choose to provide the service at a location that is outside of the closest county (or Baltimore City) in which the service is available.
Ch. 2 Provider Responsibilities

Reporting Communicable Disease

You must ensure that all cases of reportable communicable disease that are detected or suspected in an enrollee 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 an enrollee 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 provider cares for the enrollee.

- The provider report must identify the disease or suspected disease and demographics on the enrollee 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 LHD immediately.
  - 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 DHMH.

Other Reportable Diseases and Conditions

- A single case of a disease of known or unknown etiology that may be a danger to the public health, as well as unusual manifestation(s) of a communicable disease, are reportable to the LHD.
- An outbreak of a disease of known or unknown etiology that may be a danger to the public health is reportable immediately by telephone.

Reportable Communicable Diseases - Laboratory Providers

Providers of laboratory services must report positive laboratory results as directed by Health - General Article _18-205, Annotated Code of Maryland.

In order to be in compliance with the Maryland HIV/AIDS reporting Act of 2007, laboratory providers must report HIV positive members and all CD4 test results to the health department by using the member’s name. The state of Maryland HIV/CD4 Laboratory Report Form DHMH 4492 must be used. The reporting law and the revised reporting forms may be found at:

Http://dhmh.state.md.us/AIDS/HivReporting/HivReport

Laboratories that perform mycobacteriology services located within Maryland, must report all positive findings to the health officer of the jurisdiction in which the laboratory is located. For out-of-state laboratories licensed in Maryland and performing tests on specimens from Maryland, the laboratory may report to the health officer of the county of residence of the patient or to the Maryland DHMH, Division of Tuberculosis Control within 48 hours by telephone at 410-767-6698 or fax 410-669-4215.

We cooperate with LHDs in investigations and control measures for communicable diseases and outbreaks.

Following is a list of reportable communicable diseases:

Amebiasis
Anaplasmosis
Animal bites
Anthrax
Arboviral infections
Babesiosis
Botulism
Brucellosis
Campylobacter infection
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<th>Disease/Infection</th>
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<tr>
<td>Chancroid Chlamydia infection</td>
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<td>Cholera</td>
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<tr>
<td>Coccidioidomycosis</td>
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<tr>
<td>Creutzfeldt-Jakob disease</td>
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<td>Cryptosporidiosis</td>
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<td>Cyclosporiasis</td>
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<td>Dengue fever</td>
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<td>Diphtheria</td>
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<td>Ehrlichiosis</td>
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<td>Encephalitis</td>
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<td>Epsilon toxin of Clostridium perfringens</td>
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<td>Escherichia coli O157:H7 infection</td>
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<td>Giardiasis</td>
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<td>Glanders</td>
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<td>Gonococcal infection</td>
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<td>Haemophilus influenzae, invasive disease</td>
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<tr>
<td>Hantavirus infection</td>
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<tr>
<td>Harmful algal bloom related illness</td>
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<tr>
<td>Hemolytic uremic syndrome, post-diarrheal Hepatitis, Viral (A,B,C,D, non-ABC, E, F, G, undetermined)</td>
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<tr>
<td>Influenza-associated pediatric mortality</td>
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<tr>
<td>Isosporiasis</td>
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<tr>
<td>Kawasaki syndrome</td>
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<tr>
<td>Legionellosis</td>
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<tr>
<td>Leprosy</td>
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<tr>
<td>Leptospirosis</td>
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<tr>
<td>Listeriosis</td>
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<tr>
<td>Lyme disease</td>
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<tr>
<td>Malaria</td>
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<tr>
<td>Measles (rubeola)</td>
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<tr>
<td>Meningitis, infectious</td>
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<tr>
<td>Meningococcal invasive disease</td>
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<tr>
<td>Microsporidiosis</td>
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<tr>
<td>Mumps (infectious parotitis)</td>
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<tr>
<td>Mycobacteriosis, other than tuberculosis and leprosy</td>
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<tr>
<td>Novel influenza A virus infection</td>
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<tr>
<td>Pertussis</td>
</tr>
<tr>
<td>Pertussis vaccine adverse reactions</td>
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<tr>
<td>Pesticide related illness</td>
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<tr>
<td>Plague</td>
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<tr>
<td>Pneumonia in a healthcare worker resulting in hospitalization</td>
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<tr>
<th>Disease/Infection</th>
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<tbody>
<tr>
<td>Poliomyelitis</td>
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<td>Psittacosis</td>
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<tr>
<td>Q Fever</td>
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<tr>
<td>Rabies</td>
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<tr>
<td>Ricin toxin</td>
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<tr>
<td>Rocky Mountain spotted fever</td>
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<td>Rubella (German measles) and congenital rubella syndrome</td>
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<tr>
<td>Salmonellosis (non-typhoid fever types)</td>
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<tr>
<td>Septicemia in newborns</td>
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<tr>
<td>Severe acute respiratory syndrome (SARS)</td>
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<td>Shiga-like toxin producing enteric bacterial infections</td>
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<td>Shigellosis</td>
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<tr>
<td>Smallpox and other Orthopoxvirus infections</td>
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<td>Staphylococcal enterotoxin B</td>
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<td>Streptococcal invasive disease, Group A</td>
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<tr>
<td>Streptococcal invasive disease, Group B</td>
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<tr>
<td>Streptococcus pneumoniae, invasive disease</td>
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<tr>
<td>Syphilis</td>
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<tr>
<td>Tetanus</td>
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<tr>
<td>Trichinosis</td>
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<tr>
<td>Tuberculosis and suspected tuberculosis</td>
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<tr>
<td>Tularemia</td>
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<tr>
<td>Typhoid fever (case or carrier, or both, of Salmonella typhi)</td>
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<tr>
<td>Varicella (chickenpox), fatal cases only</td>
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<tr>
<td>Vibrios, non-cholera types</td>
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<tr>
<td>Viral hemorrhagic fever (all types)</td>
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<tr>
<td>Yellow fever</td>
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<tr>
<td>Yersiniosis</td>
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Outreach Requirements

UnitedHealthcare Community Plan develops an Outreach Program Plan annually. You can access a copy of the Outreach Program Plan on our website at UnitedHealthcareOnline.com > News.

Appointment Scheduling

To ensure that HealthChoice enrollees have every opportunity to access needed health-related services, as specified under COMAR 10.09.66, PCPs must develop collaborative relationships with the following entities to bring enrollees into care:

- UnitedHealthcare Community Plan;
- Specialty care providers;
- The Administrative Care Coordination Units (ACCU) at the LHD; and
- DHMH Provider Hotline staff as needed.

We will, before referring an adult enrollee to the local health department, make documented attempts to ensure that follow-up appointments are scheduled in accordance with the enrollee’s treatment plan by attempting a variety of contact methods, which may include written correspondence, telephone contact and face-to-face contact.

Prior to any appointment for a HealthChoice recipient you must call EVS at 866-710-1447 to verify recipient eligibility and MCO enrollment. This procedure will assist in ensuring payment for services.

Initial Health Appointment for HealthChoice Enrollees

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

- You determine that no immediate initial appointment is necessary because the enrollee 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 enrollees 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 provider and is not due for a well-child visit.

- For pregnant and post-partum women who have not started to receive care, the initial health visit must be scheduled and the women seen within 10 days of a request.

- As part of the enrollment process the State conducts a health risk assessment (HRA) and screens each HealthChoice recipient for conditions requiring expedited intervention by providers. HealthChoice recipients who screen positive must be seen for their initial health visit within 15 days of UnitedHealthcare Community Plan’s receipt of the completed HRA.

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 physical status, behavior of the enrollee, or laboratory findings indicate possible substance abuse, you are to perform a substance-abuse screening using an approved Substance Abuse and Mental Health Services Administration (SAMSA) screening instrument and appropriate for the age of the member.
Services for Children

For children younger than 21 years old, we shall assign the enrollee to a PCP who is certified by the EPSDT Program, unless the enrollee or enrollee’s parent, guardian, or caretaker, as appropriate, specifically requests assignment to a PCP who is not EPSDT-certified. In this case, the non-EPSDT provider is responsible for ensuring that the child receives well childcare according to the EPSDT schedule.

Wellness Services for Children Under 21 Years

Providers shall refer children for specialty care as appropriate. This includes:

- Making a specialty referral when a child is identified as being at risk of a developmental delay by the developmental screen required by EPSDT; is experiencing a delay of 25 percent or more in any developmental area as measured by appropriate diagnostic instruments and procedures; is manifesting atypical development or behavior; or has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

- Immediately refer any child thought to have been abused physically, mentally, or sexually to a specialist who is able to make that determination.

You are to follow the rules of the Maryland Healthy Kids Program to fulfill the requirements under Title XIX of the Social Security Act for providing children under 21 with EPSDT services. The program requires you to:

- Notify enrollees 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 women to the Supplemental Nutritional Program for Women, Infants and Children (WIC).

- Provide the WIC Program with enrollee information about hematocrits and nutrition status to assist in determining an enrollee’s eligibility for WIC.

- Participate in the Vaccination 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. When new vaccines are approved by the Food and Drug Administration (FDA), the VFC Program is not obligated to make the vaccine available to VFC providers. Therefore, under the HealthChoice Prescription Drug List (PDL) requirement (COMAR 10.09.67.04D(3)), we will pay for new vaccines that are not yet available through the VFC.

Enrollees under age 21 are eligible for a wider range of services under EPSDT than the adult population. PCPs are responsible for understanding these expanded services (see Section III Benefits) so that appropriate referrals are made for services that prevent, treat, or ameliorate physical, mental or developmental problems or conditions.

Appointments must be scheduled at an appropriate time interval for any enrollee who has an identified need for follow-up treatment as the result of a diagnosed condition.

Healthy Kids (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. 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 enrollee by mail, telephone and through face-to-face contact.
- Notify our Special Needs Coordinator at 410-379-3434 for assistance with outreach as defined in the provider agreement.
- 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 making a referral to the ACCU of the LHD. Use the Local Health Services request form (See: https://mmcp.dhmh.maryland.gov/docs/DHMH-4582-LHSRF-FRONT-PAGE-LHD-ACCU-10.10(web-only).pdf).
- After referring to the ACCU, work collaboratively with the ACCU and UnitedHealthcare Community Plan to bring the child into care. This collaborative effort will continue until the child complies with the EPSDT periodicity schedule or receives appropriate follow-up care.

**Special Needs Populations**

We have a Special Needs Coordinator whose focus is on the Special Needs member who may need outreach, assistance with psychosocial needs and support, transportation issues impacting access to care, and community based services.

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

- Pregnant and postpartum women.
- Children with special health care needs.
- Individuals with HIV/AIDS.
- Individuals with a physical disability.
- Individuals with a developmental disability.
- Individuals who are homeless.
- Individuals with a need for substance-abuse treatment.
- Children in state-supervised care.

**Services Every Special Needs Population Receives**

In general, 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 enrollee.
- 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 providers:

- Upon the request of the recipient or the PCP, a case manager trained as a nurse or a social worker will be assigned to the recipient. The case manager will work with the enrollee 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 enrollee 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 enrollees to specialty care networks.

- We have a special needs coordinator on staff (410-379-3434) for assistance with outreach as defined in the Provider Agreement. The special needs coordinator helps enrollees find information about their condition or suggests places in their area where they may receive community services and/or referrals.

- All of our providers 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 may be referred to the local health department for specific outreach efforts, according to the process described below.

If the PCP or specialist finds that an enrollee continues to miss appointments, UnitedHealthcare Community Plan must be informed. We will attempt to contact the enrollee by mail, telephone and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the local health department in the jurisdiction where the enrollee lives.

Within 10 days of either the third consecutive missed appointment, or you becoming aware of the patient’s repeated non-compliance with a regimen of care, whichever occurs first, you should make a written referral to the LHD ACCU using the Local Health Services Request Form (See [https://mmcp.dhmh.maryland.gov/docs/DHMH-4582-LHSRF-FRONT-PAGE-LHD-ACCU-10.10(web-only).pdf](https://mmcp.dhmh.maryland.gov/docs/DHMH-4582-LHSRF-FRONT-PAGE-LHD-ACCU-10.10(web-only).pdf)). The ACCU will assist in locating and contacting the enrollee for the purpose of encouraging them to seek care. After referral to the ACCU, UnitedHealthcare Community Plan and our providers will work collaboratively with the ACCU to bring the enrollee into care.

**Services for Pregnant and Post Partum Women**

It is important to refer all pregnant women to our Healthy First Steps program at 800-599-5985.

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

- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment form;
- Comprehensive prenatal, perinatal, and postpartum care (including high-risk specialty care). Please call us to refer all pregnant women to our Healthy First Steps Program at 1-800-599-5985;
- Development of an individualized plan of care, which is based upon the risk assessment and is modified during the course of care if needed;
- Case management services;
- Prenatal and postpartum counseling and education;
- Basic nutritional education;
- Special substance-abuse treatment including access to treatment within 24 hours of request and intensive outpatient programs that allow for children to accompany their mother;
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant women;
- Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers;
- Postpartum home visits;
- Referral to the ACCU.

The PCP, OB/GYN and UnitedHealthcare Community Plan are responsible for making appropriate referrals of pregnant enrollees to publicly provided services
that may improve pregnancy outcome. Examples of appropriate referrals include the WIC special supplemental nutritional program and the local health department’s ACCU. In connection with such referrals, necessary medical information will be supplied to the program for the purpose of making eligibility determinations.

Pregnancy-related service 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 enrollee of the prenatal appointment dates and times.

You must:

- Schedule prenatal appointments in a manner consistent with the ACOG guidelines;
- Provide the initial health visit within 10 days of the request;
- Complete the Maryland Prenatal Risk Assessment form – DHMH 4850 for each pregnant enrollee and submit it to the LHD in the jurisdiction in which the enrollee lives within 10 days of the initial visit;
- For pregnant enrollees under the age of 21, refer them to their PCP to have their EPSDT screening services provided;
- Reschedule appointments within 10 days for enrollees who miss prenatal appointments;
- Refer to the WIC Program;
- Refer pregnant and postpartum enrollees who are substance abusers for appropriate substance-abuse assessments and treatment services;
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child;
- Instruct pregnant enrollee to notify the MCO of her pregnancy and her expected date of delivery after her initial prenatal visit;
- Instruct the pregnant enrollee to contact the MCO for assistance in choosing a PCP for the newborn prior to her eighth month of pregnancy;
- Document the pregnant enrollee’s choice of pediatric provider in the medical record;
- Advise pregnant enrollee that she should be prepared to name the newborn at birth. This is required for the hospital to complete the “Hospital Report of Newborns”, DHMH 1184 and get the newborn enrolled in HealthChoice.

**Dental Care for Pregnant Enrollees**

Dental services for pregnant women are provided by the Maryland Healthy Smiles Dental Program, administered by DentaQuest. Contact them at 888-696-9596 if you have questions about dental benefits.

**Childbirth Related Provisions**

Special rules for length of hospital stay following childbirth:

- An enrollee’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 an enrollee must remain in the hospital after childbirth for medical reasons, and she requests that her newborn remain in the hospital while she is hospitalized, additional hospitalization of up to four days is covered for the newborn and must be provided.
- If an enrollee elects to be discharged earlier than the conclusion of the length of stay guaranteed by state law, a home visit must be provided.
- When an enrollee opts for early discharge from the hospital following childbirth, (before 48 hours for vaginal delivery or before 96 hours for C-section) one home nursing visit within 24 hours
after discharge and an additional home visit, if prescribed by the attending provider, are covered.

Post-natal home visits are to be performed by a registered nurse, in accordance with generally accepted standards of nursing practice for home care of a mother 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 mother;
- Blood collection from the newborn for screening, unless previously completed;
- Appropriate referrals; and
- Any other nursing services ordered by the referring provider.

If an enrollee remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider, 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 two weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit.

Children With Special Health Care Needs

UnitedHealthcare Community Plan will:

- 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. We also have a Special Needs Coordinator (410-379-3434) whose focus is on the Special Needs member who may need outreach, assistance with psychosocial needs and support, transportation issues impacting access to care, and community based services.
- 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 providers as specified in the special provisions and guidelines detailed in Section I.
- 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 recipients can appeal by calling the state’s HealthChoice Enrollee Help Line.
- Work closely with the schools that provide education and family services programs to children with special needs.
- 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**

Children with HIV/AIDS are eligible for enrollment in the REM Program. All other individuals with HIV/AIDS are enrolled in one of the HealthChoice MCOs.

The following service requirements apply for persons with HIV/AIDS:

- An HIV/AIDS specialist for treatment and coordination of primary and specialty care. To qualify as an HIV/AIDS specialist, a health care provider must meet the criteria specified under COMAR 10.09.65.10.B.

- A diagnostic evaluation service (DES) assessment can be performed once every year at the enrollee’s request. The DES includes a physical, mental and social evaluation. The enrollee may choose the DES provider from a list of approved locations or can self-refer to a certified DES for the evaluation.

- Substance-abuse treatment 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 enrollees who are individuals with HIV/AIDS to facilities or organizations that can provide the enrollees access to clinical trials.

- The LHD will designate a single staff member to serve as a contact. In all instances, providers 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 recipient to receive needed health care services.

Case management services are covered for any enrollee who is diagnosed with HIV. These services are to be provided, with the enrollee’s consent, to facilitate timely and coordinated access to appropriate levels of care and to support continuity of care across the continuum of qualified service providers. Case management will link HIV-infected enrollees with the full range of benefits (e.g. substance-abuse treatment, primary mental health care, and somatic health care services), as well as referral for any additional needed services, including specialty mental health services, social services, financial services, educational services, housing services, counseling and other required support services. HIV case management services include:

- Initial and ongoing assessment of the enrollee’s needs and personal support systems, including using a multi-disciplinary approach to develop a comprehensive, individualized service plan;

- Coordination of services needed to implement the plan;

- Periodic re-evaluation and adaptation of the plan, as appropriate; and

- Outreach for the enrollee and the enrollee’s family by which the case manager and the PCP track services received, clinical outcomes, and the need for additional follow-up.

The enrollee’s case manager will serve as the enrollee’s advocate to resolve differences between the enrollee and providers of care pertaining to the course or content of therapeutic interventions.

If an enrollee initially refuses HIV case management services, the services are to be available at any later time if requested by the enrollee. We also have a special needs coordinator who can assist with coordination of support services, community programs, transportation for access to care and other psychosocial support needs that are impacting treatment or access to care.

**Individuals With Physical or Developmental Disabilities**

Before placement of an individual with a physical disability into an intermediate or long-term care facility, UnitedHealthcare Community Plan will assess the needs of the individual and the community as supplemented by other Medicaid services. We will conduct a second opinion review of the case, performed by our medical director, before placement.
If our medical director determines that the transfer to an intermediate or long-term care facility is medically necessary and that the expected stay will be greater than 30 days, we will obtain approval from the department before making the transfer.

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 enrollees 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 enrollees have access to these services.

To request interpreter services, members or providers can contact our customer service department 24 hours a day, seven days a week. For members please contact us at 800-318-8821 and for providers please contact us at 877-842-3210 and allow at least five days advanced notice for scheduling interpreter services.

**Individuals in Need of Substance-Abuse Treatment**

As part of an enrollee’s initial health appraisal, first prenatal visit, and whenever you think it is appropriate, a substance-abuse screen must be performed, using a formal substance-abuse screening instrument that is:

- Appropriate for the detection of both alcohol and drug abuse; and
- Recommended by SAMSA and appropriate for the age of the patient.

When the substance-abuse screen yields a positive result, the enrollee may self-refer for a comprehensive substance-abuse assessment performed by a qualified provider using either:

- The Problem Oriented Screening Instrument for Teenagers (POSIT), or
- The Addictions Severity Index (ASI). A note regarding the prescribing of Suboxone (Buprenorphine). If you are a provider that is certified to prescribe this drug, be advised that there are specific requirements which must be met as part of the Prior Auth process. Please refer to our Suboxone Prior Auth form for detailed information, or call our Pharmacy department.

If the comprehensive assessment indicates that the enrollee is in need of substance-abuse treatment, a placement appraisal to determine the appropriate level and intensity of care for the enrollee must be conducted. Placement appraisal must be based on the current edition of The American Society of Addictions Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, or its equivalent, as approved by the Alcohol and Drug Administration.

Based on the results of a comprehensive assessment and a placement appraisal, the enrollee is referred to, or the enrollee may self-refer to an appropriate substance-abuse treatment modality. Substance-abuse treatment services covered for all enrollees include:

- Individual, family, or group counseling;
- Detoxification (outpatient, or, if medically necessary, inpatient);
- Opioid maintenance;
- Intermediate Care Facility-Addictions (ICF-A) intermediate treatment for enrollees younger than age 21;
- Partial hospitalization; and
- Case management.

We will not deny substance-abuse treatment solely because the enrollee has had a problem with substance abuse in the past. In addition, individuals in certain special populations are covered for some additional substance-abuse services, specifically:
Pregnant and Postpartum Women:
- Access to treatment within 24 hours of request;
- Case management; and
- Intensive outpatient programs, including day treatment that allows for children to accompany their mother.

Individuals With HIV/AIDS
Individuals with HIV/AIDS who are substance abusers will receive substance-abuse treatment within 24 hours of request.

Individuals Who are Homeless
If an individual is identified as homeless, our Special Needs Coordinator at 410-379-3434 is available to assist with access to healthcare services, and psychosocial support. The Special Needs Coordinator will work to identify any additional community programs and support services (where available) that may benefit the member. Members with Substance abuse issues, including pregnant women, should be referred to United Behavioral Health at 888-291-2507.

Adult Enrollees With Impaired Cognitive Ability/Psychosocial Problems
Support and outreach services are available for adult enrollees needing follow-up care who have impaired cognitive ability or psychosocial problems and who can be expected to have difficulty understanding the importance of care instructions or difficulty navigating the health care system.

MCO Support Services (Outreach)
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 third consecutive missed appointment, or of the enrollee’s provider becoming aware of the patient’s repeated non-compliance with a regimen of care, whichever occurs first, the provider 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, the enrollee’s provider will work collaboratively with the ACCU and UnitedHealthcare Community Plan to bring the enrollee into care.

Referral Authorization Process
Basic Guidelines
In order to alleviate some of the administrative burden on providers, written uniform referral forms are no longer required. Physicians can communicate referrals to members on a prescription pad or simply by verbal instructions. All referrals must be documented in the member’s medical record. It is important to confirm that the referral is to a participating UnitedHealthcare Community Plan provider within the member’s county. If you are unsure of the participation status of a provider, please contact Provider Services. Services provided by an out-of-network provider still require notification to UnitedHealthcare Community plan.

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 at: [UHCCommunityPlan.com](http://UHCCommunityPlan.com) > select for health care professionals > select Maryland.

A PCP or specialist can telephone or fax a prior authorization request to UnitedHealthcare Community Plan. A physician (or pharmacist) reviews all cases in which the care (or prescription medication) does not appear to meet criteria or guidelines which are 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 under-utilization nor are incentives used to encourage barriers to care and service.

The treating physician has the right to request a Peer-to-Peer discussion with the reviewing physician, 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 410-540-5965.

Members and practitioners 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 physician who was not involved in the initial denial decision and who is of the same or similar specialty as the requesting physician. 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.

It is imperative that all providers obtain necessary preauthorizations and bill the appropriate entity when a recipient is covered by Medical Assistance. Do not bill the recipient. The only exceptions to this statement are situations where a recipient knowingly chooses to be served by a provider, without the necessary preauthorization or referral, or requests an uncovered service. In such situations the 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.

**Criteria used for Medical Management Decisions**

**Externally Developed Criteria**

Nationally recognized review criteria (such as Milliman Guidelines and ASAM) are used to guide the reviewer in approving inpatient care as well as selected outpatient care and services. Criteria are reviewed and approved annually by UnitedHealthcare. Updates occur annually or when necessary or provided. Other criteria may be substituted when there is published peer reviewed literature that supports the admission or continued stay criteria. All criteria are subject to the review and approval process.

**Internally Developed Approval Criteria**

In addition to external criteria, the health plan develops standards for medical necessity (approval criteria). Nationally recognized evidence-based guidelines are reviewed, updated and approved at least every two years by UnitedHealthcare’s National Executive Medical Policy Committee and the National Quality Management Oversight Committee (NQMOC). These guidelines are reviewed and revised annually utilizing a literature review search of new articles and medical technology reviews pertaining to levels of care as well as input solicited from providers.

Medical necessity criteria are available to network physicians upon request by contacting Provider Services at 877-842-3210 or by accessing the provider website at: [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Tools & Resources > Policies & Protocols > Medical & Drug Policies & Coverage Determination Guidelines.
Communicating With Utilization Management (UM) Staff

The UnitedHealthcare Community Plan UM staff is available to discuss our UM process and/or specific UM issues during normal business hours (8 a.m. to 5 p.m.) at 866-604-3067. You can also fax information to 888-899-1681. You can leave a voicemail after hours and the UM staff will return your call or reply to your fax the next business day in compliance with the UnitedHealthcare Community Plan policy.

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-per-day, seven-days-per-week for all UnitedHealthcare Community Plan members. If after triaging the patient, a member is determined to have a nonemergency condition, that individual should be referred back to his or her PCP. If the member insists on being seen, the hospital should advise the member that the charges by the hospital might be their financial responsibility. UnitedHealthcare Community Plan provides a NurseLine service. NurseLine provides 24-hour-per-day, 365 days per year nurse advice & triage services for our members. Every call is answered by a registered nurse that works with each member to balance the Right Care, Right 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 877-440-0251.

Submitting Claims

Claims Submission Guidelines

Claims for eligible UnitedHealthcare Community Plan members may be submitted using the following methods:

- Directly to UnitedHealthcare Community Plan at UnitedHealthcareOnline.com and select “Claims & Payments”
- Paper using a CMS 1500 or UB-04 (See Attachment 3 & 4)
  - Mail to:
    UnitedHealthcare Community Plan
    PO Box 31364
    Salt Lake City, UT 84131

Claim Denials Requiring Additional Information

Claims Medical Record Submission

Certain denials may necessitate additional information in order to complete initial claim review. For example, ER and/or COB. If you received a first pass denial on revenue 452 it is because we require medical records to complete initial claim review. Records must be submitted for further processing of your claim.

To submit first-submission medical records for ER denials, please send only the original claim and a copy of medical records to the following address.

- Mail to:
  UnitedHealthcare Community Plan
  Attn: Transactions/Medical Claim Review
  PO Box 31365
  Salt Lake City, UT 84131

Claims Appeal Submission (including ER)

If after initial review of medical records you receive a denial, please follow this appeals process:

- Mail to:
  UnitedHealthcare Community Plan
  Attn: Appeals
  PO Box 31365
  Salt Lake City, UT 84131
All claims, whether paper or electronic, should be submitted using the proper CPT, ICD-10, etc. code and must match the documentation in the medical record for that visit. All claims should be submitted using standard clean claim requirements including, but not limited to:

- Member name and address
- Member group and ID number
- Place of service
- Provider name
- Provider number
- NPI number
- Tax ID number
- Diagnosis (ICD-10) codes and descriptions
- Applicable CPT/Revenue/HCPCs codes
- Applicable modifiers

If you would like any additional information about submitting claims to UnitedHealthcare Community Plan, please call the Provider Service Center at 877-842-3210 or visit UnitedHealthcareOnline.com.

**Integrity of Claims, Reports and Representation to Government Entities**

A number of federal and state regulations govern information provided to the government, including the Federal False Claims Act, State False Claims Acts, and other regulations and protections. UnitedHealth Group’s Integrity of Claims, Reports and Representations to Government Entities Policy provides information about these regulations. Providers, contractors and agents who contract with the Medicaid businesses of UnitedHealth Group or submit claims to government agencies should review this policy.

A “contractor” or “agent” includes any contractor, subcontractor, agent or other person which or who, on behalf of UnitedHealth Group, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.

Read the UnitedHealth Group’s Integrity of Claims, Reports and Representations to Government Entities Policy at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com).
Ch. 3 HealthChoice Benefits and Services

Overview

- UnitedHealthcare Community Plan must provide a complete benefit package that is equivalent to the benefits that are available to Maryland Medicaid recipients through the Medicaid fee-for-service delivery system. Carve-out services (which are not subject to capitation and are not UnitedHealthcare Community Plan’s responsibility) are still available for HealthChoice recipients. Medicaid will reimburse these services directly on a fee-for-service basis.

- A HealthChoice PCP serves as the entry point for access to health care services. The PCP is responsible for providing enrollees with medically necessary covered services, or for referring an enrollee 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 enrollee.

- An enrollee has the right to access certain services without prior referral or authorization by a PCP. This applies to specified self-referred services and emergency services. We are responsible for reimbursing out-of-plan providers who have furnished these services to our enrollees (see Self-Referral Services section on Page 30).

- Only benefits and services that are medically necessary are covered. “Medically necessary” means that the service or benefit is:
  (a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
  (b) Consistent with currently accepted standards of good medical practice;
  (c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
  (d) Not primarily for the convenience of the consumer, family, or provider.

- HealthChoice enrollees may not be charged any copayments, premiums or cost sharing of any kind, except for the following:
  - Up to a $3 copayment for brand-name drugs;
  - Up to a $1 copayment for generic drugs; and
  - Any other charge up to the fee-for-service limit as approved by the department.

- We do not impose pharmacy copayments on the following:
  - Family planning drugs and devices;
  - Individuals under 21 years old;
  - Pregnant women; and
  - Institutionalized individuals who are inpatient in long-term care facilities or other institutions requiring spending all but a minimal amount of income for medical costs.

- Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program.

- The pharmacy cannot withhold services even if the recipient cannot pay the copayment. The recipient’s inability to pay the copayment does not excuse the debt and they can be billed for the copayment at a later time. We will not restrict our enrollees’ access to needed drugs and related pharmaceutical products by requiring that enrollees use mail-order pharmacy providers.

Covered Benefits and Services
(Listed alphabetically)

Audiology Services for Adults
These services are only covered when part of an inpatient hospital stay.
Blood and Blood Products
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
Case management services are covered for enrollees who need such services including, but not limited to, members of special needs populations, which consist of the following non-mutually exclusive populations:

• Children with special health care needs;
• Individuals with a physical disability;
• Individuals with a developmental disability;
• Pregnant and postpartum women;
• Individuals who are homeless;
• Individuals with HIV/AIDS;
• Individuals with a need for substance-abuse services; and
• Children in state-supervised care.

If warranted, a case manager will be assigned to an enrollee when the results of the initial health screen are received by the MCO.

A case manager will perform home visits as necessary as part of UnitedHealthcare Community Plan case management program, and will have the ability to respond to an enrollee’s urgent care needs during this home visit. For more information regarding our case management program and how to obtain case management services, please call 410-379-3455.

Clinical Practice Guidelines
UnitedHealthcare Community Plan adopts and approves Clinical Guidelines as prescribed by the UnitedHealthcare Medical Technology Assessment Committee (MTAC).

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

Clinical Practice Guidelines (CPG) are available through UHCCommunityPlan.com. Click on “For Health Care Professionals” and then select Maryland. There will be a link to the currently approved CPGs.

Dental Services for Children and Pregnant Women
These services are provided by the Maryland Healthy Smiles Dental Program, administered by DentaQuest. Contact them at 888-696-9596 if you have questions about dental benefits.

Diabetes Care Services
UnitedHealthcare Community Plan covers all medically necessary diabetes care services that include:

• Diabetes nutrition counseling;
• Diabetes outpatient education;
• Diabetes-related DME and disposable medical supplies, including:
  – Blood glucose meters for home use;
  – Finger-sticking devices for blood sampling;
  – Blood glucose monitoring supplies; and
  – 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.

Dialysis Services
Enrollees in HealthChoice who are diagnosed with End Stage Renal Disease (ESRD) are eligible for REM. To be REM-eligible on the basis of ESRD, enrollees must meet one of the following sets of criteria:
• Children (under 21 years old) with chronic renal failure (ICD-9 code 585.1-585.6) diagnosed by a pediatric nephrologist; and
• Adults (ages 21-64) with chronic renal failure with dialysis (ICD-9 code 585.6, V45.11 and 585.9).

For those enrollees needing dialysis treatment who are enrolled in UnitedHealthcare Community Plan, dialysis services are covered, either through participating providers or, at the enrollee’s option, non-participating providers.

Disease-Management Programs
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 automatically screened when we identify them as living with a disease. UnitedHealthcare Community Plan informs practitioners of their patient’s participation. If you would like to enroll a UnitedHealthcare Community Plan member who is not currently enrolled in the program, please let us know. We will work corroboratively with you and your patients who are UnitedHealthcare Community Plan members, to identify and prevent complications, promote optimal health, and ensure quality health care. For more information about our Care Management programs, call 855-202-0713.

DMS/DME
• UnitedHealthcare Community Plan requires preauthorization for all covered DME/DMS over $500. Authorization for DME and/or DMS will be provided in a timely manner so as not to adversely affect the enrollee’s health and within two business days of receipt of necessary clinical information but not later than seven calendar days from the date of the initial request.
• Disposable medical supplies are covered, including incontinency pants and disposable underpants for medical conditions associated with prolonged urinary or bowel incontinence, if necessary to prevent institutionalization or infection, and all supplies used in the administration or monitoring of prescriptions by the enrollee.
• DME is covered when medically necessary, including but not limited to all equipment used in the administration or monitoring of prescriptions by the enrollee. We pay for any DME authorized for enrollees even if delivery of the item occurs within 90 days after the member’s disenrollment from UnitedHealthcare Community Plan, as long as the member remains Medicaid eligible during the 90-day time period.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
For enrollees under 21 years of age, all of the following EPSDT services are covered:

• Well-child services provided in accordance with the EPSDT periodicity schedule by an EPSDT-certified 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 dental screening; and
  – Health education.
• EPSDT partial or interperiodic well-child services and health care services necessary to prevent, treat, or ameliorate physical, mental, or developmental
problems or conditions, which services are sufficient in amount, duration, and scope to treat the identified condition, and are subject to limitation only on the basis of medical necessity, including:

- Chiropractic services;
- Nutrition counseling;
- Audiological screening when performed by a PCP;
- Private-duty nursing;
- DME including assistive devices; and
- Any other benefit listed in this section.

• Providers are responsible for making appropriate referrals for publicly-funded programs not covered by Medicaid, including Head Start, the WIC nutritional program, early intervention services, School Health-Related Special Education Services, vocational rehabilitation, and Maternal and Child Health Services (located at local health departments).

Family Planning Services
Comprehensive family planning services are covered, including:

- Office visits for family planning services;
- Laboratory tests including pap smears;
- Contraceptive devices; and
- Voluntary sterilization (Requires Form and Prior Authorization).

Home Health Services
Home health services are covered when the enrollee’s PCP or attending physician certifies that the services are necessary on a part-time, intermittent basis by an enrollee who requires home visits. Covered home health services are delivered in the enrollee’s home and include:

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

Hospice Care Services
Hospice care services are covered for enrollees who are terminally ill with a life expectancy of six months or less. Hospice services can be provided in a hospice facility, in a long-term care facility or at home.

Hospice providers should inform their Medicaid enrollees (or patients applying for Medicaid coverage) as soon as possible after they enter hospice care about the MCOs with whom they contract so that enrollees can make an informed choice.

We do not require a hospice care enrollee to change his/her out-of-network hospice provider to an in-network hospice provider. Hospice providers should make enrollees aware of the option to change MCOs. DHMH will allow new enrollees 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 enrollee does not change their MCO, then the MCO, which the new enrollee is currently enrolled must pay the out-of-network hospice provider.

Inpatient Hospital Services
Inpatient hospital services are covered. For special rules for length of stay for childbirth (See Page 12).
Laboratory Services
Diagnostic services, and laboratory services performed by 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 directly by the department and must be rendered by a department-approved provider and be medically necessary.

Long-Term Care Facility Services/Nursing Facility Services
Long-term care facilities include chronic hospitals, chronic rehabilitation hospitals and nursing facilities.

The first 30 days in a long-term care facility are the responsibility of UnitedHealthcare Community Plan, subject to specific rules.

When an enrollee is transferred to a long-term care facility and the length of the enrollee’s stay is expected to exceed 30 days, medical eligibility approval of the Department of Health and Mental Hygiene (DHMH) for long-term institutionalization must be secured as soon as possible.

We cover the first 30 days or until DHMH medical eligibility approval is obtained, whichever is longer. If required disenrollment procedures are not followed, our financial responsibility continues until the state’s requirements for the enrollee’s disenrollment are satisfied. In order for an enrollee to be dis-enrolled from UnitedHealthcare Community Plan based on a long-term care facility admission, all of the following must first occur:

- An application, DHMH 3871, for a departmental determination of medical necessity must be filed (If a length of stay of more than 30 days is anticipated at the time of admission, the application should be filed at the time of admission).
- DHMH must determine that the enrollee’s long-term care facility admission was medically necessary in accordance with the state’s criteria.
- The enrollee’s length of stay must exceed 30 consecutive days.
- We must file an application for disenrollment with DHMH, including documentation of the enrollee’s medical and utilization history, if requested.

Once an individual has been dis-enrolled from UnitedHealthcare Community Plan, the services they receive in a qualifying long-term care facility will be directly reimbursed by the Maryland Medical Assistance program, as long as the recipient maintains continued eligibility.

Inpatient acute care services provided within the first 30 days following admission to a long-term care facility are not considered an interruption of UnitedHealthcare Community Plan covered 30 continuous days in a long-term care facility as long as the enrollee is discharged from the hospital back to the long-term care facility.

An individual with serious mental illness, or mental retardation or a related condition may not be admitted to a nursing facility unless the state determines that nursing facility services are appropriate. For each enrollee seeking nursing facility admission, a pre-admission screening and resident review (PASRR) ID screen must be completed. The first section of the ID screen exempts an enrollee if NF admission is directly from a hospital for the condition treated in the hospital and, the attending physician certifies prior to admission to the NF that the recipient is likely to require less than 30 days of NF services.

If an enrollee is not exempted, complete the ID screen to identify whether the enrollee screens positive for mental illness or mental retardation. If the enrollee screens negative, refer to Adult Evaluation and Review Services (AERS) located in the local
health department for a STEPS assessment to help identify alternative services to NF placement.

If an enrollee is admitted into an institution for mental disease (IMD), we are responsible for an enrollee’s somatic care during the first 30 consecutive days after admission, and during stays of less than 30 days, with an overall limit of a total of 60 days per calendar year, regardless of consecutiveness. Our responsibility for an enrollee’s somatic care would continue beyond 30 consecutive days if the enrollee is not dis-enrolled from the MCO.

An enrollee admitted to an intermediate care facility–mental retardation (ICF-MR) is dis-enrolled from UnitedHealthcare Community Plan immediately upon admission to the facility, and we retain no responsibility for the enrollee’s care.

If we place an enrollee in a licensed nursing facility that is not a Maryland Medical Assistance program provider, Medicaid cannot pay the facility for services. Upon MCO disenrollment, the patient may transfer to a nursing home that accepts Medicaid payment.

If an enrollee under age 21 is admitted into an ICF-A, we are responsible for medically necessary treatment for as many days as required.

We will reserve nursing facility beds for recipients hospitalized for an acute condition within the first three days, but it’s not to exceed 15 days per single acute visit.

**Outpatient Hospital Services**
Medically necessary outpatient hospital services are covered.

**Oxygen and Related Respiratory Equipment**
Oxygen and related respiratory equipment are covered.

**Pharmacy Program**
UnitedHealthcare has an extensive pharmacy program including a PDL and pharmaceutical management procedures. Medically necessary outpatient prescription drugs are covered when prescribed by a 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 [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) > Tools & Resources > Pharmacy Resources > Medicaid.

We will expand our PDL to include new products approved by the FDA (COMAR 10.09.67.04D(3)) in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. 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 drug is not available, a new brand-name drug rated as P (priority) by the FDA will be added to the PDL. Coverage may be subject to preauthorization to ensure medical necessity for specific therapies. For formulary drugs requiring preauthorization, a decision will be provided in a timely manner so as not to adversely affect the enrollee’s health and within two business days of receipt of necessary clinical information but no later than seven calendar days from the date of the initial request. If the service is denied, UnitedHealthcare Community Plan will notify the prescriber and the enrollee in writing of the denial (COMAR 10.09.71.04).

When a prescriber believes that a non-formulary drug is medically indicated, we have procedures in place for non-formulary requests (COMAR 10.09.67.04F(2)(a)). 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 provider, by a provider to whom the enrollee has legitimately self-referred (if provided on-site), or by an emergency medical provider are covered, including:

- Legend (prescription) drugs;
- Insulin;
- Contraceptives;
- Latex condoms (to be provided without any requirement for a 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 enrollees under age 12;
- Formulas for genetic abnormalities;
- Medical supplies for compounding prescriptions for home intravenous therapy;
- Medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for an enrollee by a qualifying provider;
- Most mental health drugs are on SMHS formulary and are to be paid by SMHS; and
- Most HIV/AIDS drugs are paid directly by the state.

UnitedHealthcare Community Plan’s drug utilization review program is subject to review and approval by DHMH, and is coordinated with the drug utilization review program of the Specialty Mental Health Service delivery system.

A note regarding the prescribing of Suboxone (Buprenorphine). If you are a provider that is certified to prescribe this drug, be advised that there are specific requirements which must be met as part of the Prior Authorization process. Please refer to our Suboxone Prior Authorization form for detailed information, or call our Pharmacy department.

- Members with Substance abuse issues, including pregnant women, should be referred to United Behavioral Health at 888-291-2507

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; or
- Non-legend drugs other than insulin and enteric aspirin ordered for treatment of an arthritic condition.

**Physician and Advanced Practice Nurse 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.

UnitedHealthcare Community Plan shall clearly define and specify referral requirements to all providers.

An enrollee’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 healthcare 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 six months.
• A child who is functioning one-third 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.

**Podiatry Services**

UnitedHealthcare Community Plan provides its enrollees medically necessary podiatry services as follows:

• For enrollees younger than 21 years old.
• Diabetes care services specified in COMAR 10.09.67.24.
• Routine foot care for enrollees 21 years old or older with vascular disease affecting the lower extremities.

**Primary Care Services**

Primary care is generally received through an enrollee’s PCP, who acts as a coordinator of care, and has the responsibility to provide accessible, comprehensive, and coordinated health care services covering the full range of benefits for which an enrollee is eligible. In some cases, enrollees will opt to access certain primary care services by self-referral to providers other than their PCPs, for example, school-based health centers. Primary care services include:

• Addressing the enrollee’s general health needs;
• Coordination of the enrollee’s health care;
• Disease prevention and promotion and maintenance of health;
• Treatment of illness;
• Maintenance of the enrollee’s health records; and
• Referral for specialty care.

For female enrollees, if the enrollee’s PCP is not a women’s health specialist she may see a women’s health specialist within UnitedHealthcare Community Plan, without a referral, for covered services necessary to provide women’s routine and preventive health care services.

**Primary Mental Health Services**

• We cover primary mental health services required by enrollees, including clinical evaluation and assessment, provision of primary mental health services, and/or referral for additional services, as appropriate.
• The PCP of an enrollee requiring mental health services may elect to treat the enrollee, if the treatment falls within the scope of the PCP’s practice, training, and expertise. Neither the PCP nor UnitedHealthcare Community Plan may bill the Public Mental Health System (PMHS) for the provision of such services because these services are included in the HealthChoice capitation rates.
• When, in the PCP’s judgment, an enrollee’s need for mental health treatment cannot be adequately addressed by primary mental health services provided by the PCP, the PCP should, after determining the enrollee’s eligibility (based on probable diagnosis), refer the enrollee to the SMHS for specialty mental health services (this process is described in Section IV).

Rehabilitative Services
Rehabilitative services including medically necessary physical therapy, speech therapy, and occupational therapy for adults are covered. For enrollees under 21 rehabilitative services are covered by UnitedHealthcare Community Plan only if part of a home health visit or inpatient hospital stay. All other rehabilitative services for enrollees under 21 should be billed fee-for-service to the department.

Second Opinions
If an enrollee requests one, we will provide for a second opinion from a qualified health care professional within our network. If necessary we will arrange for the enrollee to obtain one outside of our network.

Substance-Abuse Treatment Services
Substance-abuse treatment services are covered (see Page 15).

Transplants
Medically necessary transplants are covered and Requires Prior Authorization.

Vision Care Services
UnitedHealthcare Community Plan’s vision care vendor partner is March Vision Care. March Vision Care manages and provides vision care programs for our UnitedHealthcare Community Plan members.

Vision care providers must be contracted with March Vision Care in order to service UnitedHealthcare Community Plan members.

You may direct questions to March Vision Care Provider Services at 888-493-4070. You may also submit your request via email to: providers@marchvisioncare.com.

Medically necessary vision care services are covered and include:

• One eye examination every two years for enrollees age 21 or older; or

• For enrollees under 21, at least one eye examination every year in addition to EPSDT screening, one pair of eyeglasses per year unless lost, stolen, broken, or no longer vision appropriate, and contact lenses, if eyeglasses are not medically appropriate for the condition.

Benefit Limitations
The following are not covered under HealthChoice (A complete list of benefit limitations are listed in COMAR 10.09.67.27):

• Services that are not medically necessary;

• Services not performed or prescribed by or under the direction of a health care practitioner (e.g., 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;

• Abortions (available under limited circumstances through Medicaid fee-for-service);

• Autopsies;

• 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;

• Services provided outside the United States;

• Dental services for adults, unless pregnant;
• Diet and exercise programs for weight loss except when medically necessary;

• Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when an enrollee is participating in an authorized clinical trial as specified in COMAR 10.09.67.26-1;

• Immunizations for travel outside the United States;

• 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 procedures;

• Lifestyle improvements (physical fitness programs, nutrition counseling, smoking cessation) unless specifically included as a covered service;

• Medication for the treatment of sexual dysfunction;

• Non-legend chewable tablets of any ferrous salt when combined with Vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the enrollee is younger than 12 years old;

• Non-legend drugs other than insulin and enteric-coated aspirin for arthritis;

• Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;

• Orthodontia except when the enrollee is under 21 and scores at least 15 points on the Handicapping Labio-lingual Deviations Index No. 4 and the condition causes dysfunction;

• Ovulation stimulants;

• Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis;

• Private-duty nursing for adults 21 years old and older;

• Private hospital room unless medically necessary or no other room available;

• Purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, other than for enrollees younger than 21 years old;

• Reversal of voluntary sterilization procedure;

• Services performed before the effective date of the enrollee’s coverage;

• Therapeutic footwear other than for an enrollee who qualifies for diabetes care services or for an enrollee who is younger than 21 years old; and

• Transportation services that are provided through LHDs. UnitedHealthcare Community Plan will assist enrollees to secure non-emergency transportation through their LHDs. Additionally, we provide non-emergency transportation to access a covered service if we choose to provide the service at a location that is outside of the closest county in which the service is available. The following is a list of the transportation contact numbers for each county:

<table>
<thead>
<tr>
<th>County</th>
<th>Telephone Number to Call</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alleghany</td>
<td>Alleghany Ambulance – 301-689-1133</td>
</tr>
<tr>
<td>Anne Arundel</td>
<td>AAA Transport – 301-933-4357</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>New Clients – 410-396-7007</td>
</tr>
<tr>
<td></td>
<td>Established Clients – 410-396-6422</td>
</tr>
<tr>
<td></td>
<td>(Facilities only) – 410-396-6665</td>
</tr>
<tr>
<td>County</td>
<td>Telephone Number to Call</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>Veolia Transportation – 410-783-2465</td>
</tr>
<tr>
<td></td>
<td>410-887-2828</td>
</tr>
<tr>
<td>Calvert</td>
<td>AAA Transport – 800-577-1050</td>
</tr>
<tr>
<td>Caroline</td>
<td>Best Care Ambulance – 410-476-3688</td>
</tr>
<tr>
<td>Carroll</td>
<td>Butler Medical Transport – 888-602-4007</td>
</tr>
<tr>
<td></td>
<td>410-602-4007</td>
</tr>
<tr>
<td>Cecil</td>
<td>Cecil County Health Department – 410-996-5171</td>
</tr>
<tr>
<td>Charles</td>
<td>Van Gogh – 301-609-7917</td>
</tr>
<tr>
<td>Dorchester</td>
<td>Dorchester County Health Department – 410-901-2426</td>
</tr>
<tr>
<td>Frederick</td>
<td>Transit Services of Frederick County – 301-600-1725</td>
</tr>
<tr>
<td>Garrett</td>
<td>Garrett Community Action – 301-334-9431</td>
</tr>
<tr>
<td>Harford</td>
<td>Harford County Health Department – 410-638-1671</td>
</tr>
<tr>
<td>Howard</td>
<td>AAA Transport – 800-577-1050</td>
</tr>
<tr>
<td>Kent</td>
<td>Kent County Health Department – 410-778-7025</td>
</tr>
<tr>
<td>Montgomery</td>
<td>Montgomery Co Dept of Public Works &amp; Transit – 240-777-5899</td>
</tr>
<tr>
<td>Prince George's</td>
<td>Prince George’s County Medical Assistance program – 301-856-9555</td>
</tr>
<tr>
<td>Queen Anne’s</td>
<td>QA Co Dept. of Aging – 410-758-2357</td>
</tr>
<tr>
<td>St. Mary’s</td>
<td>St. Mary’s County Health Department – 301-475-4296</td>
</tr>
<tr>
<td>Somerset</td>
<td>Shore Transit – 443-260-2300</td>
</tr>
<tr>
<td></td>
<td>Lifestar – 410-546-0809</td>
</tr>
<tr>
<td>Talbot</td>
<td>Bay Area Transportation – 800-987-9008</td>
</tr>
<tr>
<td></td>
<td>Best Care Ambulance – 410-476-3688</td>
</tr>
<tr>
<td>Washington</td>
<td>Washington County Health Department – 240-313-3264</td>
</tr>
<tr>
<td>Wicomico</td>
<td>Shore Transit – 443-260-2300</td>
</tr>
<tr>
<td></td>
<td>Lifestar – 410-546-0809</td>
</tr>
<tr>
<td>Worcester</td>
<td>Worcester County Health Department – 410-632-0092 or 0093</td>
</tr>
</tbody>
</table>
Medicaid Covered Services That are not the Responsibility of the MCO

The following services are paid by the state on a fee-for-service basis:

- Dental services for children and pregnant women of any age;
- Occupational therapy, physical therapy, speech therapy or audiology services for children under the age of 21 years old;
- Intermediate care facilities - mental retardation services are available through state facilities;
- Medical day care services are available through direct provider reimbursement by the state on a fee-for-service basis;
- Personal care services are available through direct provider reimbursement by the state on a fee-for-service basis;
- Viral load testing, genotypic, phenotypic or HIV/AIDS drug resistance testing, and enfuvirtide used in treatment of HIV/AIDS are reimbursed directly by the department if the service is rendered by a department-approved provider and medically necessary;
- Specialty mental health services (see Section IV);
- All services to individuals enrolled in the Rare and Expensive Case Management Program (see Section V);
- Service provided after the 30th day of an enrollee’s admission in a chronic hospital, rehabilitation hospital, skilled nursing facility, intermediate care facility or institution for mental disease. The 30-day limit is subject to UnitedHealthcare Community Plan receiving the department’s approval for disenrollment from our MCO;
- Health-related services and targeted case management services provided to children when the services are specified in the child’s Individualized Family Service Plan or Individualized Education Plan and provided in the schools or by community-based children’s medical services providers;
- Healthy Start Case Management Services delivered by LHDs;
- Special support services for individuals covered under the Developmental Disabilities waiver; and
- Antiretroviral drugs in American Hospital Formulary Service therapeutic class 8:18:08 used in the treatment of HIV/AIDS.

Self-Referral Services

Enrollees can elect to receive certain covered services from out-of-plan providers. UnitedHealthcare Community Plan will cover these pursuant to COMAR 10.09.67.28. The services that an enrollee has the right to access on a self-referral basis include:

- Certain family planning services including office visits, diaphragm fitting, IUD insertion and removal, special contraceptive supplies, norplant removal, depo-provera-FP, latex condoms, and PAP smear;
- Certain school-based health center services diagnosis and treatment of illness or injury that can be effectively managed in a primary care setting, well-child care and the family planning services listed above;
- Initial medical examination for a child in state-supervised care;
- Unless UnitedHealthcare Community Plan provides for the service before a newborn is discharged from the hospital, the initial examination of a newborn before discharge, if performed by an out-of-network on-call hospital provider;
- Annual Diagnostic and Evaluation Service (DES) visit for an enrollee diagnosed with HIV or AIDS;
- Continued obstetric care with her pre-established provider for a new pregnant enrollee;
• Renal dialysis services; and

• Pharmaceutical and laboratory services, when provided in connection with a legitimately self-referred service, provided on-site by the same out of plan provider at the same location as the self-referred service.

• A newly enrolled child with a special health care need may continue to receive medical services directly related to the child’s medical condition under a plan of care that was active at the time of the child’s initial enrollment, if the child’s out-of-plan provider submits the plan of care to UnitedHealthcare Community Plan for review and approval within 30 days of enrollment (For additional information, see Page 8).

• Emergency services as described in COMAR 10.09.66.08 B.

• Substance abuse services such as individual and group counseling, detoxification and inpatient care when provided by and ADAA certified provider and ASAM criteria is met.

• A comprehensive substance abuse assessment (CSAA) if the following conditions are met:
  - Recipient is not currently in substance abuse treatment.
  - Recipient has not had a CSAA during the same calendar year, and
  - The assessment provider is an ADAA certified substance abuse provider who is qualified to administer the ASI or POSIT, and the ASAM.

**Optional Services Provided by UnitedHealthcare Community Plan**

**NurseLine**

UnitedHealthCare has a 24/7 NurseLine. You can talk to a nurse, day or night. You can get advice for medical problems. The nurse can help you decide the best place to get care for you or your family’s illness or injuries. Call NurseLine 27/7 at 877-440-0251 (TTY 711).

**Routine Vision for Adults**

Adults are eligible to receive an eye examination and one pair of glasses or contacts every two years. Coverage is provided for one necessary replacement every two years.
Ch. 4 Specialty Mental Health Services

Introduction

Under the HealthChoice program we are responsible for a comprehensive package of services, with limited exceptions detailed in Section III. The HealthChoice program, however, has two significant program areas where eligible recipient’s services are not the responsibility of the MCO. These ‘carve outs’ are distinct in that one carves out a service, specialty mental health care, and the other carves out a population, individuals who qualify for the Rare and Expensive Case Management (REM program).

Specialty Mental Health Services (SMHS)

www.dhmh.state.md.us/mha

Description

In the state of Maryland, the system responsible for the delivering of mental health services to Medicaid recipients is the Public Mental Health System (PMHS). The PMHS will deliver all specialty mental health services to enrollees in HealthChoice. The Mental Hygiene Administration (MHA), in collaboration with Core Service Agencies (CSA) operate the PMHS. The MHA contracts with an Administrative Service Organization (ASO) to provide administrative management functions for all the PMHS, statewide.

Local Access to SMHS – Role of the Core Services Agencies (CSAs)

www.dhmh.state.us/mha/csa.overview

Twenty CSAs serve as the local entities in charge of the mental health service delivery system in their jurisdictions. Working in conjunction with the MHA, CSAs:

• Plan, establish, coordinate and manage publicly-funded mental health services in their respective jurisdictions. CSAs will promote the full participation of mental health recipients, family members, caregivers, local human service and health care agencies, as well as other appropriate stakeholders in developing and evaluating these services;
• Determine type and capacity need of providers to offer a comprehensive array of publicly-funded mental health services for their communities;
• Assure recipient access to services;
• Measure the quality of the services rendered; and
• Handle grievances and appeals, in accordance with COMAR.

Role of the Administrative Service Organization (ASO)

The ASO:

• Verifies the eligibility of recipients;
• Authorizes services that are determined to be medically necessary according to criteria set by the MHA;
• Refers individuals to qualified providers of public mental health services;
• Performs service utilization review to assess quality, appropriateness and effectiveness of care for the MHA in collaboration with the CSAs;
• Processes billing claims and remits payments;
• Maintains 24-hour, toll-free telephone access seven days a week for recipients at 800-888-1965. Access for providers is maintained from 8 a.m. to 6 p.m., Monday through Friday at 800-888-1965; and
• Conducts annual provider and recipient satisfaction surveys and submits results to the MHA and the CSAs.

Access to Specialty Mental Health Services

• Specialty mental health services (e.g., any mental health services other than primary mental health services) are not subject to capitation and are
not our responsibility. Even so, UnitedHealthcare Community Plan or our PCPs do have the responsibility to refer eligible enrollees to the PMHS when specialty mental health services are needed.

• An enrollee with a probable diagnosis of a mental disorder is eligible for referral to the SMHS by the PCP or UnitedHealthcare Community Plan if the following conditions are met:
  – The enrollee’s probable diagnosis of a mental disorder was established in accordance with the current American Psychiatric Association Diagnostic and Statistical Manual recognized by DHMH;
  – The probable diagnosis is not a sole diagnosis of substance abuse or dependence, dementia, or mental retardation or one of the diagnoses listed at the end of this section; and
  – The PCP or UnitedHealthcare Community Plan determines that primary mental health services provided by the PCP are insufficient to address the enrollee’s mental health treatment needs.

• A mental health professional functioning as the SMHS utilization review (UR) agent will accept preauthorization requests to determine the medical necessity for mental health assessment or treatment. The SMHS UR agent will preauthorize medically necessary services of a type, frequency, and duration that are consistent with expected results and are cost-effective.

• If the SMHS UR agent determines that there is medical necessity for specialty mental health services, the enrollee will be linked with the appropriate services.

• If the SMHS UR agent determines that specialty mental health services are not medically necessary, the SMHS UR will, as appropriate, promptly consult the referral source for assistance in developing a plan for the enrollee, to determine whether an alternative service or a service of alternate duration is appropriate.

• If the SMHS UR agent denies services, the enrollee, and the provider are notified or in writing, specifying the clinical rationale for the denial, and outlining procedures for appealing the denial.

• With the recipient’s permission, the treating mental health provider communicates directly with the PCP, to coordinate mental health and somatic care.

• The SMHS UR agent may not deny services without arranging an appropriate alternative service if the denial of services would abruptly change the enrollee’s living situation or cause severe disruption to an enrollee with serious and persistent mental illness or serious emotional disturbance.

**Referring an Enrollee to the SMHS Through a Toll-Free Help Line: 800-888-1965**

The ASO’s toll-free number is available 24-hours-a-day, seven-days-a-week and is staffed by qualified mental health professionals called care managers.

Enrollees are able to access the ASO directly or through assistance from UnitedHealthcare Community Plan, their PCP, a mental health provider, family member or caregiver. Staff is trained to handle those who are non-English speaking or hearing impaired. Back-up physician advisors will be available at all times.

Once a call is received, care managers assess requests for service using the following definitions of need:

• **Acute Crisis**- A situation in which an individual is threatening imminent harm to themself or others. The enrollee or the person making the call may state or imply that the recipient is not in control of these impulses. Help will be dispatched immediately while keeping the caller on the line with a clinician.
• **Emergency** - A situation involving an enrollee or the person making the call who states or implies that the recipient may do harm to themself or others if help is not received soon. The caller states or implies the recipient’s need for help, but may be able to maintain impulse control for several hours until help can be arranged. The care manager’s assessment of the situation presented is that acute crisis services would not be needed. In these cases, the PMHS protocols require that authorizations be made within one hour and face-to-face emergency services must be provided within four hours.

• **Urgent** - A situation in which the recipient is experiencing a decrease in self-control and increasing frustration over life events. The care manager’s assessment is that neither acute crisis nor emergency services are needed. As a result, the enrollee plans or engages in avoidance activities, such as running away rather than threatening harm to self or others. The PMHS protocols require that an urgent situation be handled through face-to-face services within 24 hours.

• **Scheduled** - A situation in which the enrollee or caller feels that the enrollee is in no immediate harm, but requires an assessment and, probably mental health services. The PMHS protocols require that recipients be seen by a provider within 10 working days.

• The PMHS will arrange for medically appropriate psychiatric consultations for any condition.

### Specialty Mental Health Diagnoses Covered by the PMHS

- 295.00 – 298.9
- 299.9
- 300.00 – 301.6
- 301.81 – 302.6
- 302.81 – 302.9
- 307.1
- 307.3
- 307.5 – 307.89
- 308.0 – 308.9
- 309.0 - 309.9
- 311
- 312.0 – 312.9
- 313.0 - 313.82
- 313.89 – 314.9
- 332.1
- 333.1
- 333.82
- 333.90
- 333.92
- 333.99
Ch. 5  Rare and Expensive Case Management (REM) Program

Overview
The Department of Health and Mental Hygiene (DHMH) administers a Rare and Expensive Case Management (REM) program to address the special needs of waiver-eligible individuals diagnosed with rare and expensive medical conditions. The REM program, a part of the HealthChoice program, was developed to ensure that individuals who meet specific criteria receive high quality, medically necessary and timely access to health services.

Qualifying diagnoses for inclusion in the REM program must meet the following criteria:

- Occurrence is generally fewer than 300 individuals per year;
- Cost is generally more than $10,000 on average per year;
- Need is for highly specialized and/or multiple providers/delivery system;
- Chronic condition;
- Increased need for continuity of care; and
- Complex medical, habilitative and rehabilitative needs.

Medicaid Services and Benefits
To qualify for the REM program, a recipient must have one or more of the diagnoses specified in the Rare and Expensive Disease List at the end of this section. The recipients may elect to enroll in the REM Program, or to remain in UnitedHealthcare Community Plan if the department agrees that it is medically appropriate. REM participants are eligible for fee-for-service benefits currently offered to Medicaid-eligible recipients not enrolled in MCOs as well as additional, optional services, which are described in COMAR 10.09.69. All certified Medicaid providers other than HMOs, MCOs, ICF-MRs and IMDs are available to REM participants, in accordance with the individual’s plan of care.

Case Management Services
In addition to the standard and optional Medicaid services, REM participants have a case manager assigned to them. The case manager’s responsibilities include:

- Gathering all relevant information needed to complete a comprehensive needs assessment;
- Assisting the participant with selecting an appropriate PCP, if needed;
- Consulting with a multi-disciplinary team that includes providers, participants, and family/caregivers, to develop the participant’s plan of care;
- Implementing the plan of care, monitoring service delivery and making modifications to the plan as warranted by changes in the participant’s condition;
- Documenting findings and maintaining clear and concise records; and
- Assisting in the participant’s transfer out of the REM program, when and if appropriate.

Care Coordination
REM case managers are also expected to coordinate care and services from other programs and/or agencies to ensure a comprehensive approach to REM case management services. Examples of these agencies and programs are:

- DHMH - Healthy Start Program – follow-up newborn assessments;
- Developmental Disability Administration - coordinate services for those also in the Home and Community-Based Services Waiver;
- DHMH - Maternal Child Health Division on EPSDT - guidelines and benchmarks and other special needs children’s issues;
- AIDS Administration - consult on pediatric AIDS;
• DHR - coordinate Medical Assistance eligibility issues; coordinate/consult with Child Protective Services and Adult Protective Services; coordinate with foster care programs;

• Department of Education - coordination with the service coordinators of Infants and Toddlers program and other special education programs; and

• Mental Hygiene Administration - referral for mental health services to the Specialty Mental Health System, as appropriate, and coordination of these services with somatic care.

**Referral and Enrollment Process**

There are members with specific diagnoses that may be suitable for REM evaluation. You may call us at 410-379-3416 and we will do an evaluation to help determine if the member meets eligibility requirements. If yes, then we will refer to the State REM office.

Candidates for REM are generally referred from HealthChoice MCOs, providers, or other community sources. Self-referral or family-referral is also acceptable. 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 determine the recipient’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 recipient and referral source.

If the intake nurse determines that the recipient has a REM-qualifying diagnosis, the nurse approves the recipient for enrollment. However, before actual enrollment is completed, the Intake Unit contacts the PCP to see if he/she will continue providing services in the fee-for-service environment. If not, the case is referred to a case manager to arrange a PCP in consultation with the recipient. If the PCP will continue providing services, the Intake Unit then calls the recipient to notify of the enrollment approval, briefly explain the program and give the recipient an opportunity to refuse REM enrollment. If enrollment is refused, the enrollee remains in the MCO. At the time of recipient notification, the Intake Unit also ascertains if the recipient is receiving services in the home (e.g., home nursing, therapies, supplies, equipment, etc). If so, the case is referred to a case manager for service coordination. We are responsible for providing the recipient’s care until the recipient is actually enrolled in the REM program. If the recipient does not meet the REM criteria, the recipient will remain enrolled in UnitedHealthcare Community Plan.

For questions or to request a REM Referral Form, please call 800-565-8190. A copy of the form can also be found in the Forms and Attachments section of this manual. Referrals may be faxed to the REM Intake Unit at 410-333-5426 or mailed to the following address:

REM Program Intake Unit  
Maryland Department of Health and Mental Hygiene  
Office of Health Services  
201 W. Preston Street, Room 210  
Baltimore, MD 21201-2399
## Table of Rare and Expensive Disease List as of July 2008

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Disease</th>
<th>Age Group</th>
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<td>Congenital absence of kidney(s)</td>
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<td>756.55</td>
<td>Chondroectodermal dysplasia</td>
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<td>756.59</td>
<td>Osteodystrophy NEC</td>
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<tr>
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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 supports efforts to deal efficiently and effectively with any identified quality issue. On a daily basis and through a systematic process of annual 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 enrollee and provider feedback is an integral part of the managed care process and helps to ensure that cost-containment activities do not adversely affect the quality of care provided to enrollees.

The department’s quality assurance monitoring plan is a multifaceted strategy for assuring that the care provided to HealthChoice enrollees 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, outcomes, measures and data reporting activities.

The department has adopted a variety of methods and data reporting activities to assess MCO service quality to Medicaid enrollees. These areas include:

- Health Risk Assessment screening conducted by the enrollment broker at the time the recipient selects an MCO to assure that the MCO is alerted to immediate health needs, e.g., prenatal care service needs.
- A complaint, grievance and appeals system administered by department staff.
- A complaint, grievance and appeals system administered by UnitedHealthcare Community Plan.
- A review of each MCO’s quality improvement processes and clinical care through an annual systems performance review 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.
- The annual collection, validation and evaluation of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a set of standardized performance measures designed by the National Committee for Quality Assurance. The measures are audited by an independent entity and results are reported to DHMH.
- The annual collection and evaluation of a set of performance measures identified by the department.
- An annual enrollee satisfaction survey using the Consumer Assessment Plans Survey.
- Monitoring of preventive health, access and quality of care outcome measures based on encounter data.
- Development and implementation of the HealthChoice outreach plan.
- A review of services to children to determine our compliance with federally required EPSDT standards of care.
- The annual production of a consumer report card.
- Health care provider will cooperate with UnitedHealthcare on any audit. The health care provider will maintain adequate medical records related to covered services rendered by medical group. If records are requested by UnitedHealthcare, the health care provider shall provide copies of records free of charge. The health care provider will allow access to UnitedHealthcare or its designees medical records, in connection with enrollees care.
management/utilization, quality assurance and improvement. The Medical group will provide access during business hours within 14 business days after request is made, except in cases of a UnitedHealthcare audit involving fraud or safety of an enrollee, in which, access shall be given within 48 hours after the request.

- Physicians and providers must allow the plan to use physician and provider performance data.

- Your office hours of operation may not be less for Medicaid members that the office hours for Commercial members.

**Quarterly Complaint Reporting**

We are responsible for gathering and reporting to the state information about enrollee’s appeals and grievances and our interventions and resolution to these appeals and grievances. The reports contain data on appeals and grievances in a standardized format and are submitted on a quarterly basis. To accomplish this, we are required to operate a Consumer Services Hotline and Internal complaint process.

**MCO Member Hotline**

UnitedHealthcare Community Plan maintains a Member Services unit that operates a hotline 24 hours a day, 7 days a week. This unit handles and resolves inquiries and complaints and also refers members to other agencies for assistance if needed. Members may reach the hotline at 800-318-8821

**MCO Enrollee Complaint Policy and Procedures**

UnitedHealthcare Community Plan has written complaint policies and procedures whereby an enrollee who is dissatisfied with the MCO or its network may seek recourse verbally or in writing from the HealthChoice Enrollee Help Line staff. UnitedHealthcare Community Plan must submit its written internal complaint policy and procedures to the department for its approval.

UnitedHealthcare Community Plan internal complaint materials are developed in a culturally sensitive manner, at a suitable reading comprehension level, and in the enrollee’s native tongue if the enrollee is a member of a substantial minority. UnitedHealthcare Community Plan delivers a copy of its complaint policy and procedures to each new enrollee at the time of initial enrollment, and at any time upon an enrollee’s request.

UnitedHealthcare Community Plan includes in its written internal complaint process the procedures for registering and responding to appeals and grievances in a timely fashion. These procedures include resolving emergency medically-related complaints within 24 hours, non-emergency medically-related complaints within five days and administrative complaints within 30 days. In addition, the written procedures:

1. Require documentation of the substance of the complaints and steps taken to resolve;
2. Include participation by the provider, if appropriate;
3. Allow participation by the ombudsman, if appropriate;
4. Ensure the participation of individuals within the MCO who have the authority to require corrective action;
5. Include a documented procedure for written notification on the outcome of our determination.
6. Include a procedure for immediate notice to the department of all disputed denials of benefits or services in emergency medical situations;
7. Include a procedure for notice to the enrollee through an Adverse Action Letter that meets the approval of the department of all disputed denials, reductions, suspensions, or terminations of services or benefits;
8. Include an appeal process which provides, at its final level, an opportunity for the enrollee to be heard by our Chief Executive Officer, or their designee;
(9) Include a documented procedure for reporting of all complaints received by us to appropriate parties; and

(10) Include a protocol for the aggregation and analysis of complaints and grievance data and use of the data for quality improvement.

No punitive action will be taken against the enrollee for making a complaint against us or the department.

Appeals
If the member wants to file an appeal with us, they have to file it within 90 days from the date of receipt of the denial letter.

You can also file an appeal for them if the member signs a form giving you permission. Other people can also help the member to file an appeal such as a family member or a lawyer.

When the member files an appeal, or at any time during our review they should be sure to provide us with any new information that they have that will help us make our decision.

When reviewing the member’s appeal we will:

- Use doctors with appropriate clinical expertise in treating the enrollee’s condition or disease;
- Not use the same MCO staff to review the appeal who denied the original request for service; and
- Make a decision about administrative appeals within 30 days.

If the member’s doctor or UnitedHealthcare Community Plan feels that the member’s appeal should be reviewed quickly due to the seriousness of the member’s condition, the member will receive a decision about their appeal within three business days.

The appeal process may take up to 44 days if the member asks for more time to submit information or if we need to get additional information from other sources. We will send the member a letter if we need additional information.

If the member’s appeal is about a service that was already authorized and they were already receiving, they may be able to continue to receive the service while we review their appeal. The member should contact us at 877-842-3210 if they would like to continue receiving services while their appeal is reviewed. 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.

Once we complete our review, we will send the member a letter letting them know our decision. If we decide that they should not receive the denied service, that letter will tell them how to file another appeal through us or ask for a State Fair Hearing.

Grievances
If the member’s complaint is about something other than not receiving a service, this is a grievance. Examples of grievances would be: not being able to find a doctor, trouble getting an appointment, or not being treated fairly by someone who works at UnitedHealthcare Community Plan or at the doctor’s office.

If the member’s grievance is:

- About an urgent medical problem that they are having, it will be solved within 24 hours.
- About a medical problem but it is not urgent, it will be solved within five days.
- Not about a medical problem, it will be solved within 30 days.

If a member would like a copy of our official complaint procedure or if they need help filing a complaint, they can call 800-318-8821.
**UnitedHealthcare Community Plan**  
**Provider Complaint Process**

**Claim Denials Requiring Additional Information Claims Medical Record Submission**

Certain denials may necessitate additional information in order to complete initial claim review. For example, ER and/or COB. If you received a first pass denial on revenue 452 it is because we require medical records to complete initial claim review. Records must be submitted for further processing of your claim.

To submit first-submission medical records for ER denials, please send only the original claim and a copy of medical records to the following address:

- Mail to:  
  UnitedHealthcare Community Plan  
  Attn: Transactions/Medical Claim Review  
  PO Box 31365  
  Salt Lake City, UT 84131

**Claims Appeal Submission (including ER)**

If after initial review of medical records you receive a denial, please follow this appeals process:

- Mail to:  
  UnitedHealthcare Community Plan  
  Attn: Appeals  
  PO Box 31365  
  Salt Lake City, UT 84131

**INQUIRIES**

**Inquiry**- a verbal request from a Medicaid provider for clarification, additional information, or explanation of a plan service, operation, administration, procedure, or benefit. UnitedHealthcare’s Customer Service department is responsible for handling and resolving inquiries from Medicaid providers.

**THE REVIEW PROCESS**

In general, it is the intention of UnitedHealthcare to try to resolve provider issues at the earliest point possible. UnitedHealthcare’s Customer Service department is the first point of contact for provider calls. The Customer Service department will document the provider’s issue in UnitedHealthcare’s electronic documentation system. If the provider is dissatisfied with the explanation to their inquiry, they may pursue the issue further. The Customer Service department will be responsible for informing providers of their right to pursue the issue and file a complaint if they remain dissatisfied.

Examples include, but are not limited to requests for the following information:

- Eligibility;
- Benefits info;
- Claim status;
- Claim adjustment due to processing error (informal requests); and
- Network information.

Request for reconsideration of previously adjudicated claim, if no specific argument is included as to why the provider believes the claim was adjudicated incorrectly.

**COMPLAINTS**

**Complaint** - A complaint is an expression of dissatisfaction which results in an appeal or a grievance, but a complaint without a clear expression of the provider’s desire for reconsideration of a plan determination is not an appeal. NOTE: An expression of dissatisfaction over a previously processed claim which the complainant wants reconsidered is an appeal.

Examples of complaints include, but are not limited to:

- Dissatisfaction regarding a service that has already been received or dissatisfaction regarding a UnitedHealthcare policy.

A provider, may pursue another review of their issue by contacting UnitedHealthcare by telephone or in writing. The provider should clearly explain the nature of their request and provide applicable supporting
documentation. Providers can also find out about the appeals and grievance process by contacting the Provider Service line which is available 24-hours-a-day, seven-days-a-week. UnitedHealthcare Community Plan will make the complaint process known to providers upon the point of contract, through the provider manual and at any time upon request. UnitedHealthcare’s Customer Service department is typically the first point of contact for a provider’s complaint. If, however, the provider is dissatisfied with the resolution given on the call, the provider can contact UnitedHealthcare’s Provider Claim Service Unit to complain, either verbally or in writing. Clinical quality-of-care issues related to a UnitedHealthcare network provider are referred to UnitedHealthcare’s Quality Improvement department for investigation.

**REVIEW PROCESS**
The complaint will be handled by UnitedHealthcare’s Appeals and Grievance Unit, who will issue an acknowledgment to the provider. The Appeals and Grievance Unit will be responsible for documenting receipt of the complaint, the substance of the complaint and the subsequent resolution of the complaint in UnitedHealthcare’s electronic documentation system. Notification to the provider will be provided within 30 days of receipt of the complaint.

UnitedHealthcare Community Plan Provider Appeal Process

**APPEALS**
A provider appeal is a request by a provider, participating or non-participating, for a review and/or reconsideration of a previously processed claim that was partially paid or denied for a service that has already been provided.

A provider may also appeal when a determination or a grievance is not resolved to the provider’s satisfaction or if UnitedHealthcare acts to reduce, suspend or terminate a provider’s participation with UnitedHealthcare.

**REVIEW PROCESS**
Appeals from providers will be thoroughly investigated and reviewed by clinicians as appropriate.

UnitedHealthcare Community Plan will render a decision within sensitive timelines that recognize the need for expediency.

A provider has 90 business days from the date of the denial to file an initial appeal. The appeal must be in writing and submitted to the following address:

United Healthcare Grievance & Appeals Department
PO Box 31364
Salt Lake City, UT 84131-0364

UnitedHealthcare will notify the provider of the first-level determination within 40 days of receipt of appeal.

**ACKNOWLEDGEMENT**
For appeals received by the appeals department at the address published above, denial letter or remittance advice, UnitedHealthcare will send written acknowledgment to the provider of receipt of the appeal within five business days.

If the provider is unsatisfied with UnitedHealthcare’s determination on the appeal, the provider may appeal to UnitedHealthcare again. This is the final level of appeal and will be reviewed by the UnitedHealthcare CEO or his/her designee.

If the provider chooses to utilize the second level of appeal, the appeal must be received by UnitedHealthcare within 15 business days of the date of the determination on the first level of appeal. UnitedHealthcare will notify the provider of the second and final level determination within 35 days of receipt of appeal.

This appeal policy applies to all participating providers, non-participating providers and any agents acting on their behalf (e.g., law firms or collection agencies). If a provider chooses to utilize an agent acting on its behalf, the appeal filed by that agent is considered one
of the levels of appeals. No additional reviews will be granted to outside agents apart or above and beyond the process outlined herein.

UnitedHealthcare will resolve denials of payment appeals within 90 business days of receipt of the initial appeal by UnitedHealthcare.

CLAIMS PAYMENT
For overturned appeals, UnitedHealthcare will forward the claim for adjustment and the claim will be paid within 30 days of the decision to overturn the appeal.

DATA ANALYSIS AND REPORTING
UnitedHealthcare will aggregate Medicaid administrative complaint and appeal data, including medically-related complaints and appeals. This data will be analyzed for the purpose of tracking and trending the substance of Medicaid providers’ issues. The analyzed data will be reported to the Service Quality Improvement Committee on a periodic basis, or as otherwise required. The Service Quality Improvement Committee will determine whether any quality improvement recommendations should be developed based on the data. This data will be available to any and all representatives of DHMH upon request by the department.

DMHM Quality Oversight: Complaint and Appeal Processes
The HealthChoice and Acute Care Administration operates the central complaint investigation process. The Enrollee Help Line and the Complaint Resolution and Provider Hotline Units, are responsible for the tracking of both provider and enrollee complaints and grievances called into the hotlines, or sent to the Department in writing.

Enrollee Help Line
The Enrollee Help Line (EHL) is available Monday through Friday from 7:30 a.m. to 5:30 p.m. at 800-284-4510 or TDD at 800-735-2258 for the hearing impaired. The EHL is typically an enrollee’s first contact with the department. Help-line staff is trained to answer questions about the HealthChoice program. EHL staff will:

- Direct recipients to our member services line when needed;
- Attempt to resolve simple issues by contacting us or other parties as needed; and
- Refer medical issues to the department’s Complaint Resolution Unit for resolution.

The EHL has the capability to address callers in languages other than English either through bilingual staff or through the use of a language line service.

The EHL uses an automated system for logging and tracking enrollee inquiries and grievances. Information is analyzed monthly and quarterly to determine if specific intervention with a particular MCO is required or changes in state policies and procedures are necessary.

Provider Hotline
The Provider Hotline provides HealthChoice providers access to DHMH staff for grievances and inquiries. Provider Hotline staff respond to general inquiries and resolves complaints from providers concerning enrollee access and quality of care as well as educating providers about the HealthChoice program. The telephone number for the Provider Hotline is 800-766-8692; TDD 800-735-2258. We will not take any punitive action against you for accessing the Provider Hotline.

As with the EHL, provider inquiries and complaints are tracked and analyzed monthly and quarterly to determine if specific intervention with particular MCOs is required or changes in state policies and procedures are necessary.

Complaint Resolution Unit
The Complaint Resolution Unit is a unit in the Outreach and Care Coordination Division of the HealthChoice and Acute Care Administration.
Roles and Responsibilities
Calls are referred by either the Enrollee Help Line or the Provider Hotline. With a staff of nurses and a physician consultant trained to address complex issues that may require medical knowledge, the Complaint Resolution Unit serves in the following capacities:

• Advocates on the caller’s behalf to obtain resolution of the issue;
• Communicates with our staff, providers, and advocacy groups to resolve the issue and/or secure possible additional community resources for the enrollee’s care when needed;
• Assists enrollees and providers in navigating the MCO system;
• Utilizes the local health department Ombudsman program to provide localized assistance;
• Facilitates working with us and our providers to coordinate plans of care that meet the enrollees’ needs.
• Coordinates the state appeal process relating to a denied covered benefit or service for the enrollee.

The Complaint Resolution Unit operates Monday through Friday from 7:30 a.m. to 5:30 p.m. and has the capability to address recipients in languages other than English through the use of a language line service.

Ombudsman/Administrative Care
Coordination Unit (ACCU) Program The department operates an Ombudsman/ACCU program for the purpose of investigating disputes between enrollees and MCOs referred by the department’s complaint unit. The ombudsman educates enrollees about the services provided by UnitedHealthcare Community Plan and their rights and responsibilities in receiving services from us. When appropriate, the ombudsman may advocate on the enrollee’s behalf, including assisting the enrollee to resolve a dispute in a timely manner using our internal grievance and appeals process.

The Ombudsman program is operated locally in each county of the state, under the direction of the department. In most jurisdictions, LHDs carry out the local ombudsman function. A LHD that desires to serve as both the county ombudsman and as a MCO subcontractor must first secure the approval of the secretary of the department and of the local governing body. In addition, a LHD may not subcontract the ombudsman program.

Local ombudsman programs include staff with suitable experience and training to address complex issues that may require medical knowledge. When a complaint is referred from the department’s complaint unit, the local ombudsman may take any or all of the following steps, as appropriate:

• Attempt to resolve the dispute by educating the MCO or the enrollee;
• Utilize mediation or other dispute resolution techniques;
• Assist the enrollee in negotiating our internal complaint process; and
• Advocate on behalf of the enrollee throughout our internal grievance and appeals process.

All cases referred to the Ombudsman/ACCU will be resolved within the time frame specified by the department’s Complaint Resolution Unit or within 30 days of the date of referral.

The local ombudsman does not have the authority to compel us to provide disputed services or benefits. If the dispute is one that cannot be resolved by the local ombudsman’s intervention, the local ombudsman will refer the dispute back to the department for resolution. A LHD may not serve as ombudsman for cases in which the dispute between the enrollee and us involves the services of the LHD as a MCO subcontractor. The department conducts a periodic review of the Ombudsman program activities as part of the quarterly and annual complaint review process.
Departmental Dispute Resolution
When an enrollee does not agree with the MCO’s decision to deny, stop, or reduce a service, the enrollee can appeal the decision. The enrollee can contact the EHL at 800-284-4510 and tell the representative they would like to appeal the MCO’s decision. The appeal will be sent to a nurse in the Complaint Resolution Unit. The Complaint Resolution Unit will attempt to resolve the issue with the MCO in 10 business days. If it cannot be resolved in 10 business days, the enrollee will be sent a notice that gives them a choice to request a fair hearing or wait until the Complaint Resolution Unit has finished its review. When the Complaint Resolution Unit is finished working on the appeal, the enrollee will be notified of their findings.

If the department disagrees with our determination, it may order us to provide the benefit or service immediately.

If the department agrees with our determination to deny a benefit or service, it will issue written notice within 10 business days to the enrollee, stating the grounds for its decision and explaining the enrollee’s appeal rights. The enrollee may exercise their right to an appeal by calling 888-767-0013 or by completing the Request for a Fair Hearing form attached to their appeal letter and sending it to:

Susan J. Tucker, Executive Director
Attn: Dina Smoot
Office of Health Services
201 W. Preston Street, Room 127
Baltimore, MD 21201

Enrollee Appeal
A HealthChoice enrollee may exercise their appeal rights pursuant to State Government Article, _10-201 et seq., Annotated Code of Maryland. An enrollee may appeal a departmental decision that:

(1) agrees with our determination to deny a benefit or service;

(2) denies a waiver-eligible individual’s request to dis-enroll; or

(3) denies an enrollee eligibility in the REM program.

The enrollee may appeal a decision to the Office of Administrative Hearings. In appeals concerning the medical necessity of a denied benefit or service, a hearing that meets department-established criteria, as determined by the department, for an expedited hearing, shall be scheduled by the Office of Administrative Hearings, and a decision shall be rendered within three days of the hearing. In cases other than those that are urgent concerning the medical necessity of a denied benefit or service, the hearing shall be scheduled within 30 days of receipt by the Office of Administrative Hearings of the notice of appeal and a decision shall be rendered within 30 days of the hearing. The parties to an appeal to the Office of Administrative Hearings under this section will be the department and the enrollee, the enrollee’s representative or the estate representative of a deceased enrollee. We may move to intervene as a party aligned with the department.

We will provide all relevant records to the department and provide witnesses for the department, as required.

Following the hearing, the Office of Administrative Hearings issues a final decision. The final decision is appealable to the Board of Review pursuant to Health-General Article, _2-201 to 2-207, Annotated Code of Maryland. The decision of the Board of Review 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.

Reference to Member Rights and Responsibilities Statement being published in the provider manual is on page 2 of the Spring 2011 Practice Matters.
# ATTACHMENT 2 - LOCAL RESOURCES

## LOCAL RESOURCES

| Allegany County Health Department (301) 777-5600 | Harford County Health Department (410) 638-8400 |
| Anne Arundel County Health Department (410) 222-7375 | Howard County Health Department (410) 313-6363 |
| Baltimore County Health Department (410) 887-3740 | Kent County Health Department (410) 778-1350 |
| Baltimore City Health Department (410) 396-4388 | Montgomery County, DHHS (240) 277-1245 |
| Calvert County Health Department (410) 535-5400 | Prince George's County Health Department (888) 883-7834 |
| Caroline County Health Department (410) 479-8030 | Queen Anne's County Health Department (410) 758-0720 |
| Carroll County Health Department (410) 876-2152 | St. Mary's County Health Department (301) 475-4330 |
| Cecil County Health Department (410) 996-5550 | Somerset County Health Department (443) 523-1700 |
| Charles County Health Department (301) 609-6901 | Talbot County Health Department (410) 819-5600 |
| Dorchester County Health Department (410) 228-3223 | Washington County Health Department (240) 313-3260 |
| Frederick County Health Department (301) 631-3111 | Wicomico County Health Department (410) 543-6930 |
| Garrett County Health Department (301) 334-7700 | Worcester County Health Department (410) 632-1100 |
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.

MEDIARE AND CHAMPUS PAYMENTS: A patient’s signature requests that payment be made and authorizes release of any information necessary to process the claim and obtain 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 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 copayment services. Coinsurance and the deductible are applied 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 FICA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FICA instructions regarding required procedure and documentation referred to above.

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’s 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 an employee, 2) they must not exceed the scope of the physician’s service, although incidental, and 3) they must be of a kind commonly furnished by a physician’s office, 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 was an active duty member of the Uniformed Services or civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 2550). For Black-Lung claims, I further certify that the services performed were for a Black Lunge-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.33).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may be upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE: PATIENT ABOUT THE USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed to the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information under Section 41(U.S.C.1301), 1962, 1972 and 1974 of the Internal Revenue Service Act as amended, 42 CFR 411.24(a) and 404.5(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 claim benefits under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services furnished were medically indicated and necessary for the health of the patient, and for the equitable payment of the claim.

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 pay primary to Federal programs, 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 as stated in the Office of Management and Budget’s system of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 30-70-051, titled, Medicare Claims Record, published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.


FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSES: To determine eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services furnished were authorized by law.

ROUTINE USES: Information from claims and related documents may be used to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or its contractors, as permitted by applicable law, to conduct audit, evaluate, and/or monitor CHAMPUS/CHAMPAG, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Comptroller General for administrative and non-personal services, the legislative or judicial branches, to Congress, or to other Federal agencies, for purposes of administrative or programmatic nature.

For CHAMPUS claims, I further agree to provide information to the Federal government, and other government agencies, in accordance with applicable laws.

DISCLOSURE: Voluntary, full, or provide information will result in delay in payment or may result in denial of claim. With the 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 the claims under this program. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1122B of the Social Security Act and 31 USC 3301-3312 provide penalties for withholding this information.

You should be aware that P.L. 100-509, 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 for furnishing 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 cooperate, if payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized withholding of income, co-payments or similar cost-sharing amounts.

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 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 0990-0099. 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 sources, 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 Office, 7500 Security Boulevard, Baltimore, Maryland 21244-1950. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.
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**Due From Patient**
Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or 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 particular terms of the release forms that were executed by the patient or the patient’s legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

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 Christian Science Sanitoriums, verifications and if necessary re- verifications of the patient’s need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1933f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing 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 their request, necessary authorization is on file. The patient’s signature on the provider’s request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers’ compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

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.

9. For CHAMPUS purposes:

This is to certify that:

(a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

(b) the patient has represented that by a reported residential address outside a military treatment center, CHAMPUS he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance 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 coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

(d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS 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 but excluding contract surgeons or other personnel employed by the Uniformed Services through 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 the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

(h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, 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. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.
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
Leptospirosis
Listeriosis
Lyme disease
Malaria
Measles (rubeola)
Melioidosis
Meningococcal invasive disease
Meningitis, infectious Microsporidiosi
Mumps (infectious parotitis)
Mycobacterioses, other than tuberculosis and leprosy
Novel influenza A virus infection
Pertussis
Pertussis vaccine adverse reactions
Peste des petits ruminants
Plague
Pneumonia in a healthcare worker resulting in hospitalization
Polio
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 - resistant staph aureus (Vrsa)
Vancomycin - resistant staph (Vrs)
Varicella (chickenpox), fatal cases only
Vibrio, noncholera
Viral hemorrhagic fevers (all types)
Yellow fever
Yersiniosis
ATTACHMENT 6

Specialty Mental Health Diagnoses Covered by the Public Mental Health System

ICD-9 CM Diagnoses

295.00 – 298.9
299.9
300.00 – 301.6
301.81 – 302.6
302.81 – 302.9
307.1
307.3
307.5 – 307.89
308.0 – 308.9
309.0 – 309.9
311.0 – 311.9
312.0 – 312.9
313.0 – 313.82
313.89 – 314.9
332.1
333.1
333.82
333.90
333.92
333.99
## ATTACHMENT 7

Schedule of Preventive Screenings

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<tr>
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<td>Health Maintenance Exam</td>
<td>Every 5 Years</td>
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<td>Colorectal Cancer- Fecal Occult Blood</td>
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### Maryland Healthy Kids Preventive Health Schedule

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<th>Late Childhood (years)</th>
<th>Adolescence (yrs)</th>
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<tr>
<td>Tuberculosis</td>
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<td>Heart disease/cholesterol</td>
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<td>Sexually transmitted infections (STI)</td>
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<tr>
<td><strong>Laboratory Tests</strong></td>
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<tr>
<td><strong>Immunizations</strong></td>
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<td>History of immunizations</td>
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<td>Vaccines given per schedule</td>
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<td><strong>Health Education</strong></td>
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<td>Age-appropriate education/guidance</td>
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<td>Counsel referral for identified problems</td>
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<td>Dental education/referral</td>
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<td>Scheduled return visit</td>
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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 2 years through 20 years. *Refer to AAP 2006 Policy Statement referenced in the Healthy Kids Program Manual - Screening required using standardized tools. Newborn Hearing Screen follow-up required for abnormal results. Blood Pressure measurements in infants and children with specific risk conditions should be performed at visits before age 3 years.

www.dhmh.maryland.gov/epsdt/