



Maryland PBHS Provider Manual

January 2020

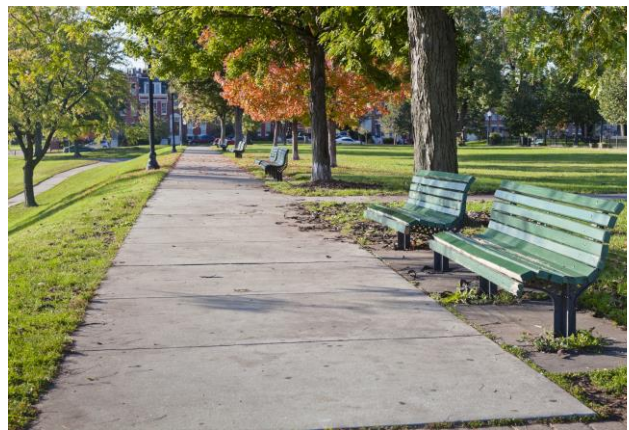


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1. Introduction

Maryland Public Behavioral Health System (PBHS)

1.1 Background

In accordance with state legislation, the Maryland Department of Health (MDH), Medicaid Office of Health Services, and the Behavioral Health Administration (BHA) implemented a new integrated Public Behavioral Health System (PBHS) in January 1, 2015. The Medicaid Office of Health Services and BHA oversee and have the authority over the PBHS, which includes policy development, statewide planning, resource allocation, and continuous quality improvement strategies. Effective January 1, 2020, Optum is the Administrative Service Organization (ASO) contracted with MDH to assist with the management of the PBHS.

This manual should be used as a reference guide when you need information specific to this Maryland PBHS membership. Any revisions will be placed on the Optum Maryland website, available at: maryland.optum.com. If you cannot find an answer to your question, please refer to Section 1.4. Contact Information.

1.2 Welcome

Maryland Medicaid, the BHA, and Optum welcome you to the network of providers for the Maryland PBHS. As a provider participating in the PBHS, you will be working with us to provide effective behavioral health services to individuals who qualify under the Maryland PBHS. We are excited to work with you to provide the right care at the right time to meet treatment, rehabilitation, and recovery goals for the participants of the PBHS.

Participation in this provider network requires providers to have an active Maryland Medicaid number and a National Provider Identifier (NPI). You must have both in place and on file with Optum in order to be part of this network and eligible for payment of services. Maryland has implemented the ePREP system for enrollment and maintenance of required provider data. See section 2 of this manual for more information on obtaining and use of required Medicaid and NPI numbers. This manual also outlines other network requirements including but not limited to eligibility and service requirements and authorization procedures for provider participation in the PBHS.

Maryland Medicaid, the BHA, and Optum are committed to continuous quality improvement that includes ongoing review of our regulations, processes, and procedures. Updates and revisions are made to this manual based on new or revised guidance from the MDH. These manual updates will be available on the Optum website. Once again, we welcome you as a provider in the Maryland PBHS and look forward to collaborating with you to make the health care system better for everyone.

1.3 Responsibilities

The successful management and implementation of a behavioral health system requires active engagement across the care and service continuum. Maryland's goal in integrating services is to build on the existing strengths of the public behavioral health programs and the Medicaid program in order to:

- Improve services for individuals with co-occurring conditions
- Expand access to appropriate mental health and addiction services
- Capture and analyze data regarding overall population health, and the use and cost of care, for behavioral health services
- Expand public health initiatives
- Reduce the cost of care through prevention, use of evidence-based practices, and reducing unnecessary or duplicative services

To this end, MDH, Optum, and providers have unique responsibilities, which are highlighted below.

MDH Responsibilities

MDH, specifically Maryland Medicaid and the BHA, is responsible for:

- Developing and evaluating policies, drafting regulations, and overall administration of behavioral health services to participants in Maryland
- Establishing provider rates and setting the benefit design standards including the amount, duration, and scope requirements
- Setting medical necessity standards
- Establishing utilization review and prior authorization criteria
- Ensuring a process for clinical reviews and participant appeals
- Setting provider participation, compliance, integrity, and audit standards and methods
- Developing claims and encounter data submission standards
- Establishing and managing other data and reporting standards
- Monitoring the Optum contract and performance in Maryland

Optum Responsibilities

Optum is responsible for:

- Managing behavioral health services for Medicaid participants, eligible uninsured individuals, and some grant-funded services
- Maintaining online authorization applications and pre-authorizing non-emergency care
- Maintaining 24-hour access for clinically-related calls
- Referring individuals to qualified service providers
- Conducting utilization review of services

- Processing claims and remitting payments
- Assisting with the evaluation of the PBHS via provider and participant satisfaction surveys
- Auditing providers for quality of documentation and correct billing practices
- Webinar trainings and regional forums addressing topics of interest to providers, PBHS participants, and advocates working to meet the behavioral health needs of the community
- Conducting provider and participant forums (such as the Provider Council) to obtain feedback regarding the performance of the PBHS
- Defining and evaluating performance, outcomes, effectiveness, efficiency, and cost-effectiveness of mental health and substance use disorder-related services and systems
- Collecting and analyzing behavioral and other health-related information

Provider Responsibilities

Providers are responsible for:

- Exercising sound clinical judgment
- Working with participants to provide quality services that meet their goals and needs
- Cooperating and collaborating with Optum concerning appropriate clinical care for participants
- Obtaining or completing pre-authorization, authorization, or registration as required for appropriate services
- Engaging in responsible management of behavioral health care by adhering to ethical and professional standards
- Maintaining a high standard of medically necessary, efficient, and cost-effective care that addresses each participant's individual needs
- Working with Optum Care Managers and participants to achieve participant satisfaction with service regulations, policies, and procedures
- Involving participants in treatment/service planning
- Delivering services consistent with the principles of recovery and resiliency
- Coordinating treatment with other involved health care providers
- Promoting innovation and best practices in services and systems
- Helping participants obtain appropriate benefits
- Honoring each participant's right to dignity and confidentiality
- Complying with local, state, and federal laws and regulations
- Complying with federal, state, Medicaid, and Medicare rules, as well as with PBHS guidelines and requirements

1.4 Contact Information

Key Phone Numbers

Phone	
Provider Enrollment	1-844-463-7768
Recipient Enrollment	1-855-642-8572
EVS – Eligibility Verification	1-866-710-1447
Optum (toll-free, follow prompts)	1-800-888-1965

Addresses

Optum
10175 Little Patuxent Parkway
Columbia, MD 21044

Claim Submission:

Optum Maryland
P.O. Box 30531
Salt Lake City, UT 84130

Websites

The following are websites where additional contact information may be found.

- **Maryland Department of Health (MDH):** [FREQUENTLY-REQUESTED-NUMBERS.pdf](#)
- **Optum Maryland:** maryland.optum.com

2. Provider Enrollment: Guidance on Participation in PBHS

Maryland PBHS

This section provides information about your responsibilities as a provider in the Maryland Public Behavioral Health System (PBHS).

Maryland Public Behavioral Health Providers include Practitioners:

- Authorized under the Code of Maryland Health Occupations Article, including specialty mental health and/or substance use disorder services
- Approved or licensed under at least one of the following:
 - Maryland Department of Health (MDH) regulations
 - Health Services Cost Review Commission (HSCRC)-regulated services
 - Federally Qualified Health Centers (FQHCs)

You may access general information about participation in the PBHS here:

mmcp.health.maryland.gov/Pages/Provider-Information.aspx

You may access provider enrollment and re-enrollment materials on the MDH Provider Enrollment page: mmcp.health.maryland.gov/Pages/Provider-Enrollment.aspx.

You are responsible for keeping up-to-date with all of the information impacting the delivery and payment of PBHS services. Therefore, you should regularly review information from Optum, MDH, and the Behavioral Health Administration (BHA) websites. Links to the websites of these organizations are included below.

- Optum Maryland: maryland.optum.com
- Maryland Department of Health (MDH): health.maryland.gov/pages/home.aspx
- The Behavioral Health Administration (BHA): bha.health.maryland.gov
- You should contact your local Core Service Agency (CSA), Local Behavioral Health Authority (LBHA) and/ or Local Addiction Authority (LAA) for concerns about local services and supports. For a list of CSAs, LBHAs and LAAs by county, please visit the Maryland Association of Behavioral Health Authorities' (MABHA) website at marylandbehavioralhealth.org/.

Participating providers are required to comply with all Federal and State regulations governing service delivery.

Medicaid and National Provider Identifier Number Requirements

In order to participate, you, or your organization, must have an active Medicaid (MA) number to deliver Medicaid reimbursable services. In addition, *separate National Provider Identifier (NPI) and MA numbers are required in order to deliver more than one type of approved or licensed service at the same location or for the same service provided at multiple locations.* Examples:

- A provider with an Outpatient Mental Health Clinic (OMHC), Psychiatric Rehabilitation Program (PRP), and Opioid Treatment Program (OTP) at one location must obtain separate NPI/MA numbers for each program.
- A provider with three separately licensed OMHCs in three different locations will need three separate NPI/MA numbers.

You may contact the Medicaid Provider Enrollment Department at 1-844-463-7768 with questions or to determine if you have an active MA number.

Maryland Medicaid Enrollment

Providers must enroll in Maryland Medicaid (refer to the ePREP section below) in order to deliver Medicaid reimbursable services. As noted above, *providers delivering more than one type of approved or licensed service must obtain separate Medicaid (MA) and NPI numbers for each Medicaid service and service location.*

To obtain new NPI numbers, you must contact The National Plan and Provider Enumeration System (NPPES) at nppes.cms.hhs.gov/#/. Maryland Medicaid assigns MA numbers when your enrollment application is approved and processed.

Please ensure that you follow all MDH instructions and that all the required documentation is attached to the application. The certifications and licenses identified in the application must be obtained prior to submission. For more specific questions related to enrollment, please send an email message to mdh.bhenrollment@maryland.gov.

Information regarding provider accreditation and licensing for behavioral health providers is available at: BHA – Accreditation and Licensing Information for Behavioral Health Providers bha.health.maryland.gov/Pages/Accreditation-Information.aspx .

ePREP for Provider Medicaid Enrollment and Registration with Optum

The state of Maryland has implemented the **electronic Provider Revalidation and Enrollment Portal** (ePREP). This resource enables online provider enrollment, re-enrollment, revalidation, information updates, and demographic changes.

For resources to assist you with ePREP, visit the Maryland Department of Health Provider Enrollment information page mmcp.health.maryland.gov/Pages/ePREP.aspx.

To create a user profile or log into an existing account for Maryland Medicaid's ePREP portal, visit ePREP.health.maryland.gov.

After enrollment at Maryland Medicaid, register with Optum using Incedo Provider Portal.

Exclusions of Individuals and Entities from Federally Funded Health Care Programs

All PBHS providers are responsible for checking the Department of Health and Human Services' Office of Inspector General's (DHHS-OIG) website to assure that they are not wrongfully contracting or employing an excluded individual. The DHHS-OIG website is oig.hhs.gov/exclusions. Providers should also check the MDH Sanctioned Providers List:

mmcp.health.maryland.gov/Pages/About-Our-Programs.aspx. It is every individual's and agency's responsibility to assure that all staff working in programs, either through direct service or administrative support, are eligible to participate in programs receiving federal reimbursement. Failure to screen employees and contractors or retain documentation that such screening has been performed, can result in disciplinary action.

Reporting Potential Fraud, Waste and Abuse

Providers must be on alert for potential fraud, waste, and abuse within the PBHS. The reporting of potential fraud, waste, and abuse is intended to avoid the misappropriation of Federal, State, and Local funds. In addition, fraud, waste, and abuse can jeopardize the care and treatment of individuals receiving, or in need of, behavioral health services. Providers are obligated to report such occurrences to Optum or the appropriate state entity. The following are resources to report potential fraud, waste, and abuse:

Program and Network Integrity (PNI) - Optum Anti-Fraud, Waste and Abuse program

Phone: 1-877-972-8844

Email: optum.pni.tips@optum.com

Mail: P.O. Box 30535
Salt Lake City, UT 84130-0535

Fax: 1-248-733-6379

General inquiries (communications to Optum PNI other than Tips):

optum.pni.communications@optum.com

Maryland Attorney General, Medicaid Fraud Control Unit

Phone: 1-410-576-6521

Email: MedicaidFraud@oag.state.md.us

MDH – Office of the Inspector General

Phone: 1-866-770-7175

Email: DHMH.OIG@Maryland.gov

Online complaint form: health.maryland.gov/oig/Pages/Report_Fraud.aspx

2.3 Provider Types

In addition to reviewing information in this manual, and before you begin the application process, take time to review relevant state regulations to determine the appropriate provider type to select. The table below includes links to some helpful sections from COMAR Title 10 Subtitles 9 (Medical Care Programs) and 63 (Community-based Behavioral Health Programs and Services).

10.09.36	General Medical Assistance Provider Participation Criteria
10.09.59	Specialty Mental Health Services
10.67.08	Maryland Medicaid Managed Care Program: Non-Capitated Covered Services
10.09.80	Community-based Substance Use Disorder Services
10.63	Community-based Behavioral Health Programs and Services
10.09.06	Adult Residential Substance Use Disorder Services

Note that COMAR 10.63 requires maintenance of key staff in order to operate, including:

- OMHC – Medical Director
- OTP – Medical Director
- PRP (Adult and Minor) – Rehabilitation Specialist

In addition, Medicaid Regulations under COMAR 10.09.06, 10.09.59, and 10.09.80 require other staff as well for other programs.

In the event your Agency loses a key employee, you must immediately file for a variance to avoid being out of compliance and at risk for paid claims being retracted. You may reference the [COMAR 10.63 Licensed Agencies: Loss of Required Staff and Site Address Changes Provider Alert](#) (issued January 2018) for more information including how to file for variance.

The following provider types may provide behavioral health services and are required to submit Maryland Medicaid applications:

Provider Type	Description	Classification
06	Special Other Acute Hospitals	Facility
07	Special Other Chronic Hospitals	Facility
10	Laboratory	Facility
15	Psychologist	Individual
20	Physician (includes psychiatrist)	Individual or Group
23	Nurse Practitioner; Certified Registered Nurse Practitioner (CRNP)	Individual or Group
24	Nurse Psychotherapist (Advanced Practice Registered Nurse-Psychiatric Mental Health [APRN-PMH])	Individual
27	Mental Health Group Therapy Provider	Group
32	Clinic, Drug	Facility
34	Federally Qualified Health Center (FQHC) (found under Clinic, FQHC)	Facility
50	Substance Use Disorder Program (Behavioral Health Administration (BHA) Certified/ Approved SUD Program)	Facility
54	IMD Residential SUD for Adults (providers treat adult recipients 18 years and older)	Facility
55	Intermediate Care Facility (IFC) – Addiction (providers treat recipients <21 years of age)	Facility
80	Physician Assistant	Individual
81	Case Management – Not elsewhere classified	Facility
88	Residential Treatment Center (RTC)	Facility
89	1915(i) Intensive Behavioral Services for Children, Youth and Families (Refer to Provider Type “HG” for individual or group provider)	Facility or Program
94	Social Worker (must have LCSW-C license)	Individual
AB	ABA Services, see Applied Behavior Analysis	Individual or Group
CC	Certified Professional Counselor (includes LCPC, LCMFT, and LCADC)	Individual
CM	Mental Health Case Management Provider	Facility
HG	1915(i) Intensive Behavioral Services for Children, Youth and Families (Refer to Provider Type “89” for facility/program provider)	Individual or Group
MC	Outpatient Mental Health Clinic (OMHC)	Facility
MH	Community Based Partial Hospitalization Program	Facility
MT	Mobile Treatment Program	Facility
PR	Psychiatric Rehabilitation Services Facility	Facility
SE	Supported Employment	Facility
VC	HIV Case Management	Facility

Note: Medicaid (MA) numbers must be associated with valid provider types and statuses.

Please visit the Maryland Department of Health Provider Enrollment page at mmcp.health.maryland.gov/Pages/Provider-Enrollment.aspx to for more information and to see State Approved Medicaid Provider Types for the PBHS.

Individual Providers:

Providers may enroll in Maryland Medicaid as sole practitioners, but they may also affiliate with a group or FQHC.

Individual behavioral health providers who participate in the Maryland Medicaid program must:

- Have an active board license or certification:
 - Providers who are not independently licensed (LGPC, LGSW, LGMFT, LGADC, LCSW) cannot enroll individually in Maryland Medicaid, nor may they be reimbursed for services provided in an individual or group practice.
- Obtain an individual NPI number:
 - Only one NPI number is necessary for individual providers regardless of the number of practice locations. The primary practice location will be listed in the Medicaid system
- Obtain a Medicaid number
- Register with Optum using Incedo Provider Portal in order to obtain authorization prior to service delivery and for reimbursement

Group Providers:

A group provider is an administrative entity that manages a cohort of individual practitioners. Group behavioral health providers must:

- Have a group of at least 2 individually licensed providers who are separately enrolled in Medicaid
 - Cannot include practitioners who are not independently licensed (i.e., LGPC, LGSW, LGMFT, LGADC, LCSW)
 - Supervisors may not receive reimbursement for services rendered by supervisees who are not independently licensed
- Obtain an organizational NPI number. Group providers may obtain an organizational NPI for each service location or select one service location to list in the Medicaid system but practice at multiple locations.
- Obtain a Medicaid number
- Register with Optum using Incedo Provider Portal in order to obtain authorization prior to service delivery and for reimbursement

Facility/Program Providers:

Facilities/organizations are licensed/certified/approved by MDH (BHA), and accreditation agencies, Core Service Agencies, Local Addictions Authorities, Local Behavioral Health Authorities, accrediting bodies, and Medicaid staff prior to enrollment. Facilities may

receive reimbursement for services delivered by individuals who are under the direct supervision of appropriately licensed staff but are not independently licensed themselves. Facilities providing behavioral health services must:

- Maintain an active provider license and accreditation status
- Obtain an organizational NPI number for each provider type and service location
- Obtain a Medicaid number for each provider type and service location
- Register with Optum using Incedo Provider Portal in order to obtain authorization prior to service delivery and for reimbursement

2.4 Enrollment and Application Information and Resources

The Maryland Medicaid Provider Enrollment page will guide you and your organization to the proper resource for enrollment based on your Provider Type. Most solo practitioners, rendering only providers and groups must enroll online using ePREP. Most providers classified as Facilities will be directed to the appropriate paper application.

You may refer to the Provider Type table in section 2.3 to locate your provider type. On the Provider Enrollment page, mmcp.health.maryland.gov/Pages/Provider-Enrollment.aspx you will be directed either to ePREP, or to the appropriate paper application marked by an “X.”

The example below shows a number of behavioral health provider types listed alphabetically. Individual and/or group classified providers (Psychologist, Physician, and Physician Assistant) are all directed to ePREP. Facility classified providers (Partial Hospitalization Program and Psychiatric Rehab Services Facility) are directed to the appropriate paper form by clicking the “X.”

1 PROVIDER TYPE DESCRIPTION	2 PT CODE	3 INDIVIDUAL	GROUP	FACILITY
PODIATRY PROVIDERS	11	ePREP	ePREP	
PSYCHOLOGIST	15	ePREP		
PHYSICAL THERAPIST	16	ePREP	ePREP	
PHYSICIAN	20	ePREP	ePREP	
PERSONAL CARE MONITOR	47			ePREP
PEDIATRIC NURSING/HOME HEALTH AIDE SERVICES AGENCY	53			X
PORTABLE X-RAY	59			X
PHYSICIAN ASSISTANT	80	ePREP		
PRESCRIBING PROVIDER	92	ePREP		
PARTIAL HOSPITALIZATION PROGRAM	MH			X
PSYCHIATRIC REHAB SERVICES FACILITY	PR			X
PHARMACY	RX			ePREP

ePREP: electronic Provider Revalidation and Enrollment Portal

The state’s ePREP enables online provider enrollment, re-enrollment, revalidation, information and demographic updates.

For additional information and resources related to ePREP, including “ePREP Basics for

Behavioral Health Providers” and FAQs, visit the Department of Health’s ePREP page: mmcp.health.maryland.gov/Pages/ePREP.aspx.

You may also log on directly to the ePREP here: eprep.health.maryland.gov/sso/login.do.

Approval

Maryland Medicaid sends letters to providers to notify them of their enrollment status. The letters contain the providers’ Medicaid Numbers and effective dates. Maryland Medicaid does not backdate applications. The effective date of the account is the date the completed application was processed.

Services delivered before the MA number is active, or those that have not been authorized by the ASO will not be reimbursed.

2.5 Provider Terminations

Notifications

According to the Medicaid Provider Agreement, providers are required to notify the MDH Provider Enrollment Department at 1-844-463-7768 within 5 working days of any of the following:

- Revocation, suspension, restriction, termination, or relinquishment of any provider licenses, authorizations, program approvals, or accreditations, whether voluntary or involuntary
- Any indictment, arrest, or conviction for felony charges or a criminal charge other than traffic offenses
- Revocation, suspension, restriction, termination or relinquishment of medical staff membership or clinical privileges at any healthcare facility

Voluntary Termination

Providers must notify the MDH Behavioral Health Unit by sending an email message to MDH.bhenrollment@maryland.gov or call the Provider Enrollment Department at 1-844-463-7768 to end their participation in the PBHS. Programs licensed under COMAR 10.63 must follow requirements set forth in COMAR 10.63.06 regarding sale or transfer of a license, or discontinuation of program operations.

Involuntary Termination

MDH will notify providers of termination from participation in the PBHS for loss of license, certification, approval, or other reasons for loss of eligibility.

2.6 Out-of-State Emergency / Urgent Care (Medicaid Benefit Only)

In the event of an emergency, a participant traveling out-of-state may receive care from a non-registered provider. In those cases, providers must apply to Maryland Medicaid to receive reimbursement for claims if they are not already enrolled. Please see section 2.2 for additional information on Maryland Medicaid enrollment.

Providers should contact Optum at 1-800-888-1965 to request a courtesy review while they are awaiting enrollment.

2.7 Participant Referral

Medicaid and non-Medicaid consumers, who are referred to or contact Optum for behavioral health services, will be referred to provider(s) according to the policies outlined below:

- Open Referral Process: Referrals may be initiated by the participant, the participant's primary care provider, a family member, or legal guardian.
- Participant Choice: MDH values participant choice. The wishes and needs of the participant drive the referral process. As such, participants will always be given a choice of providers.
- Participant preferences may include:
 - Provider location
 - Availability of transportation to provider office
 - Provider office hours
 - Gender of provider
 - Cultural sensitivity and language
- Participant needs will be identified in the following areas:
 - Clinical
 - Child or adolescent
 - Geriatric
 - Pregnant women and women with children
 - Deaf or hard of hearing
 - Language
 - Veterans

Consumers may search for a provider using the online provider directory on the Optum Maryland website at maryland.optum.com.

3. Uninsured Eligible Consumers

PBHS Maryland

3.1 Overview

As the Administrative Services Organization (ASO), Optum Maryland, receives and manages all Medicaid and state only funds for the Public Behavioral Health System (PBHS). Services are fully integrated into one common data system.

3.2 Uninsured Eligible

Uninsured eligible consumers are individuals for whom the cost of medically necessary and appropriate community-based behavioral health services will be subsidized by the Behavioral Health Administration (BHA) because of the severity of illness and financial need. Depending on the availability of state funding, services may be provided to consumers who meet specific eligibility guidelines.

Providers can verify a consumer’s eligibility or initiate a request for uninsured eligibility through Incedo Provider Portal or by calling the Optum Maryland customer service team at 1-800-888-1965.

3.3 Registering a New Participant

After logging into Incedo Provider Portal, you can search for a participant to learn whether the individual is already in the PBHS. When the participant is not in the PBHS, the participant must be added to the system in order for Optum Maryland to assign the participant an Optum Maryland medical record number.

The screenshot shows a web form titled "Add Member". It contains several sections of input fields:

- Member Identification:** ID (text), Suffix (dropdown), Last Name* (text), First Name* (text), Middle (text), Gender* (dropdown).
- Birth Date*:** (date input), **SSN:** (text), **Language 1:** (dropdown), **Language 2:** (dropdown), **Religion:** (dropdown).
- Race:** (dropdown), **Ethnicity:** (dropdown), **External ID:** (text), **Additional Number:** (text).
- Member Profile Note:** (text area).
- Status:** (dropdown) with a [Change Status](#) link.

Address Details

Date From:* 06/12/2019 Date To: ___/___/___ Verified Address Mail Undeliverable Mail Declined

Address Type:* Private Residence

Address:*

City:* State:* --- Select One --- ZIP:* County:

Country:* UNITED STATES

Demographic Notes:

Contact Information

Phone Preference:* --- Select One --- Preferred Communication Method: CellPhone

Home Number: OK to Followup

Work Number: Ext: OK to Followup

All Phone Type: --- Select One --- All Phone: All Ext: OK to Followup

Email: Email Type: --- Select One --- Follow-up? Preferred

[Add Personal Info](#) [Add Educational Info](#) [Add Special Needs & Accessibility](#)

Personal

Marital Status: --- Select One --- Veteran Status: --- Select One --- Driver's License No: Date Issued: Expiration Date:

Education

Grade Level: --- Select One --- Institution Name:

Special Needs & Accessibility

Financial Ability to Pay: MMW Pregnant? Due Date:

Handicapped Access Visually Impaired Assistance Hearing Impaired Assistance

The screenshot shows a web form titled "Insurance Information". It contains the following fields and controls:

- Date From:** A text input field containing "02/01/2019".
- Date To:** A date selection field with a calendar icon.
- Status:** A dropdown menu with the text "--- Select One ---".
- Insurer:** A text input field with a "Select Insurer" button.
- Plan:** A dropdown menu.
- Group:** A dropdown menu.
- Business Unit:** A text input field with a "Select BU" button.
- Employee:** A checkbox.
- Waive Co-Pay:** A checkbox.
- Policy Number:** A text input field.
- HIPAA Subscriber ID:** A text input field.
- Verified By:** A text input field.
- Verified On:** A date selection field.
- Insurer Notes:** A large text area for notes.

3.4 Uninsured Application for Eligibility

When applying for uninsured eligibility in Incedo Provider Portal, you will be notified immediately, of a consumer's uninsured eligibility status.

There are six criteria for uninsured eligibility and all six must be met in order for the consumer to be eligible. You are required to verify and document the consumer meets the following six uninsured eligibility criteria:

1. The consumer requires treatment for one or more behavioral health diagnoses covered by the PBHS.
2. The consumer meets the financial criteria (under 250% of federal poverty level) and is not covered by Medicaid or other insurance.
 - The service provider is responsible for collecting and maintaining documentation from the consumer that validates the consumer's financial need. This may include documentation of application and outcome for benefits, pay stubs, other income, etc. to document that the consumer meets the financial criteria.
3. The consumer has a verifiable social security number.
4. The consumer is a Maryland resident.
5. The consumer has applied for Medicaid, the Health Care Exchange, Social Security Income (SSI), or Social Security Disability Insurance (SSDI), if they have an illness/disability for a period of 12 months or more (or are expected to have an illness/disability for 12 months or more).
 - If the consumer is not eligible for Medicaid, SSI, or SSDI, documentation from Medicaid or Social Security stating the reason for ineligibility must be provided and maintained in the consumer's medical record.
6. The individual meets U.S. citizenship requirement.

BHA is requiring providers to maintain documentation in the medical record to validate the individual's uninsured eligibility. Optum Maryland and BHA will be monitoring requests for uninsured eligibility spans and providers without documentation may be audited. Failure to maintain all supporting documentation may result in a retraction of funds.

Exceptions to the documentation requirement may be made by BHA under extenuating circumstances. The exceptions are related to the type of crisis and type of service. If a consumer is in immediate need for services (such as acutely suicidal) or the consumer's symptoms prevent that person from being able to provide information and they are being seen by an assertive community treatment team, mobile crisis team, residential crisis program, or other outpatient setting, documentation criteria may be waived.

If an individual is in immediate need of services, the consumer will be given an uninsured span of 90 days. If at the end of the 90-day period the consumer still is in crisis and documentation is still not available, the provider may request another 90 days by completing the registration for the uninsured span again. If at the end of the second 90-day period, the provider again requests an uninsured eligibility span without the documentation, the request will be denied and the provider must submit a written request to the Core Service Agency (CSA), Local Behavioral Health Authority (LBHA), or Local Addiction Authority (LAA) to demonstrate the need for continued services in spite of the missing documentation.

If Optum Maryland denies the request for an uninsured eligibility span due to the individual not meeting the minimum criteria, the provider may request a review by the CSA, LBHA or LAA for an exception to the criteria due to an urgent care or special exception need.

The provider may call or fax a request for urgent care using the designated forms to the CSA, LBHA or LAA of the consumer's county of residence. The CSA, LBHA or LAA will review the request to determine if an urgent care need is met and an exception will be granted. Rationale for the exceptions is to include discharge/release or diversion from a state hospital or other inpatient setting or detention center. If the CSA, LBHA or LAA denies the request, the CSA, LBHA or LAA notifies the provider.

If CSA, LBHA or LAA approves the exception, the CSA, LBHA or LAA forwards the "State of Maryland - Request for Reimbursement for Non-Medicaid Outpatient Services" form (if member number, Medicaid ID is available) to Optum Maryland.

The "Maryland: Provider Request to CSA, LBHA or LAA for Urgent Care for Uninsured" form will not be sent to Optum Maryland but retained by the CSA. Upon receipt, Optum Maryland will enter the consumer information into our system typically is within 24 hours but no later than two business days. Optum Maryland will update the form with the consumer ID and email it back to the CSA, LBHA or LAA with a copy to the provider. The form requires the provider's email address be included.

If the CSA, LBHA or LAA approves, then an uninsured eligibility span is established. If at any point during this process, the provider updates the uninsured consumer's eligibility record with the missing documentation, the uninsured eligibility span is established for three months from the initial begin date of the uninsured span.

Additionally, there are other exceptions to documentation if the consumer meets these criteria:

1. If the individual meets all of the above documentation criteria except item 2 and one of the following:

- a. Is under age 19
 - b. Has been released from prison, jail or Department of Corrections facility within the last three months
 - c. Is pregnant
 - d. Is an injection drug user
 - e. Has HIV/AIDS
 - f. Was discharged from a Maryland-based psychiatric hospital within the last three months
 - g. Was discharged from a Maryland-based medically-monitored residential treatment facility within the last 30 days (American Society of Addiction Medicine Level 3.7)
 - h. Is requesting services required by HG 8-507 order or referred by drug or probate court
 - i. Is receiving services as required by an order of conditional release
2. If an individual meets all criteria except items 2 and 5 and is currently receiving SSDI for mental health reasons
 3. If an individual meets all criteria except items 2 and 4 and is homeless within the state of Maryland
 4. If an individual meets all criteria except items 2, 3 and 5 and is a veteran
 5. If a non-U.S. citizen, the exception process will be used which requires approval from the CSA, LBHA or LAA

3.5 Uninsured Eligibility for Behavioral Health Services

An open and active uninsured eligibility span will allow Optum Maryland to pay for some medically necessary, behavioral health services. Optum Maryland may make payment for behavioral health services provided to an uninsured eligible consumer if all of the following are met:

- The consumer meets all the requirements for uninsured eligibility
- The provider has maintained documentation that the uninsured eligibility criteria have been met
- The behavioral health services have been authorized as medically necessary, prior to services beginning (except for urgent services)
- The behavioral health services requested are one of the following:
 - Mental health case management
 - Outpatient Mental Health Clinic services (OMHCs)
 - Excluding OMHCs in HSCRC regulated space

- Excluding intensive outpatient services
 - Outpatient mental health office services (non-OMHCs)
 - Respite services
 - Enhanced support services
 - Psychiatric Rehabilitation Program (PRP) services, on and off-site*
 - Mental health residential crisis services**
 - Mobile treatment services**
 - Supported employment services***
 - Residential Rehabilitation Program (RRP) services****
 - SUD Outpatient Level 1
 - SUD Methadone Maintenance (Opioid Treatment Program services)
 - SUD Intensive Outpatient
 - SUD Residential ASAM Level 3.1
 - SUD Residential ASAM Level 3.3
 - SUD Residential ASAM Level 3.5
 - SUD Residential ASAM Level 3.7
 - SUD Residential ASAM Level 3.7WM
- The state only funds remain available for the requested behavioral health services

Uninsured requests in which the consumer does not have a primary behavioral health diagnosis or is not a Maryland resident will be denied without opportunity for exception.

3.6 Coordination of Care

For consumers with simultaneous Medicare and/or commercial coverage, a coordination of benefits (COB) is required of Optum Maryland. Optum Maryland will coordinate benefits with the primary insurer before mental health benefits can be paid against the uninsured eligibility span. Optum Maryland may pay for services to a dually insured consumer, under an uninsured eligibility span, if the consumer is:

- A Medicare beneficiary, and Medicare does not cover this service, and the individual does not have other insurance to cover the service
- Covered by a commercial insurance and the benefit for this service is exhausted, there is no benefit for this service, or the service was deemed not medically necessary by the insurer and the provider has exhausted all appeal options.

COB for both Medicare and commercial insurance is not required for the following services:

- Supported employment services

- Residential Rehabilitation Program (RRP) services
- Respite services
- Enhanced support services
- Psychiatric Rehabilitation Program (PRP) services
- Occupational therapy services*

For individuals ages 18-64 who are uninsured, have SSDI/SSI, are employed, and are requesting authorization for behavioral health services, Optum Maryland will direct the provider to apply for Employed Individuals with Disabilities (EID) benefits on behalf of the individual. EID eligibility information and application instructions are available on the MDH website at mmcp.health.maryland.gov/eid/Pages/Home.aspx . Before an uninsured request is determined, BHA is requiring an EID application be submitted. Exceptions will be granted only for an urgent care and referrals from state hospitals.

For veterans in Maryland, BHA will provide gap services, outpatient treatment, and crisis intervention services until their U.S. Veterans Administration benefits are activated and available.

Financial data must be reviewed annually, documented, and maintained in the consumer's medical record.

For sections 3.5 and 3.6

- * Consumers must meet additional criteria to qualify for these services
- ** No copays apply to PBHS funded services
- *** The individual's income from supported employment will not be included in the income verification
- **** Consumers are required to contribute to the cost of care for RRP

3.7 Uninsured Certification Periods

When a request meets the state's uninsured eligibility criteria, the uninsured eligibility span will be for three months. This is the eligibility span for both new requests and for when these spans are eligible for renewal. Individuals must meet financial need criteria of income of under 250% of federal poverty level and other required conditions.

Recertification Process

Changes during the three-month period that may impact eligibility must be reported to Optum by the consumer or provider. , The PBHS requires every provider to request that each consumer/applicant apply for any Medicaid benefits or EID for which he/she may be eligible.

Requests for uninsured eligibility will not be backdated unless the consumer has an open authorization with an end-date beyond the end-date of the consumer's current uninsured eligibility span. Backdating of uninsured eligibility spans will be allowed in the following scenarios:

- The consumer was discharged from a hospital will backdate to discharge date
- The notification of termination of Medicaid is within 30 days of the requested

uninsured start date

- The consumer is receiving care in a designated hospital diversion program

4. General Provider Information

PBHS Maryland

4.1 Provider Registration

Providers who provide Medicaid reimbursable services must be enrolled in the Maryland Medicaid program in order to be a provider for the PBHS and to deliver services to PBHS participants. Refer to section 2 for more information.

To access the MDH Provider Enrollment page, visit: mmcp.health.maryland.gov/Pages/Provider-Enrollment.aspx.

Following state enrollment, if required, you will be provided with access to Incedo Provider Portal where you will register with Optum.

4.2 Provider Training

Optum provides training for providers and their staff.

Training opportunities and related materials will be posted to the Optum Maryland website maryland.optum.com > Behavioral Health Providers > Provider Training and Education.

4.3 Provider

Provider Alerts

Optum will email Provider Alerts to announce important information, such as changes within the PBHS, Maryland Department of Health (MDH) announcements, and important regulatory guidance. Providers should register for Provider Alerts by sending an email to: marylandprovideralerts@optum.com. This subject line should read "Provider Alerts" and the provider's email address should be in the body of the email.

All Provider Alerts are also posted on the Optum Maryland website accessible here: maryland.optum.com > Behavioral Health Providers > Provider Alerts.

5. Websites and e-Services

Get registered, enrolled and connected

5.1 Optum Maryland

The Optum Maryland website includes both public information and access to secure transactions. For providers, publicly accessible information located under the Behavioral Health Providers menu includes:

- Maryland Data Initiative
- Provider Information, including reimbursement
- Provider Training & Education
- Provider Alerts
- Provider Manual
- Provider Forms
- Outcomes Measurement System (OMS)

Incedo Provider Portal secure transactions include:

- Update ancillary provider demographic information (e.g., hours, languages spoken)
- Eligibility inquiry
- Initiate authorization requests
- Electronic claim submission

<https://maryland.optum.com/content/ops-maryland/maryland/en/bh-providers.html>

After enrollment at Maryland Medicaid, register with Optum using Incedo Provider Portal.

Optum Maryland website (maryland.optum.com) contains information about Optum Maryland and its business. Links to information and documents important to providers are located here on the **Behavioral Health Providers** link, including additional information pertaining to Optum Maryland's E-commerce Requirement. Providers can also access Incedo Provider Portal, as well as view a copy of Optum Maryland's Notice of Privacy of Practices regarding the use of the website.

Please note: Optum Maryland's website includes Terms and Conditions that cover areas specific to "No Warranties," "Exclusion of Liability," "Indemnification," "Jurisdiction" and "General Provisions," as well as technical assistance related to the installation and use of this software. Technical assistance includes, but is not limited to, any guidance, recommendation, instruction, or action taken by Optum Maryland or its employees, including where such activity is performed directly on your system, device, or equipment by a Optum Maryland employee or other representative.

5.2 Clearinghouses

Electronic claim submission is also accepted through clearinghouses. When using the

services of a clearinghouse, providers must reference Optum Maryland's Payer ID "OMDBH" to ensure Optum Maryland receives those claims.

5.3 Electronic Payments and Statements (EPS)

Optum Maryland has partnered with Payspan to provide electronic claim reimbursement and remittance advice (EOP) for our providers.

This free service electronically deposits Optum Maryland provider reimbursement payments to the bank account(s) of your choice via electronic funds transfer (EFT) and provides online access to Explanation of Payments (EOPs) and payment reconciliation reports. This service allows our providers to reduce costs, improve cash flow, and reduce paper usage. Information explaining the services offered by Payspan, the benefits of the Payspan solution, and how to register your practice for the service can be found at payspanhealth.com/nps/Support/Index.

Payspan provides payment automation services that improve administrative efficiency, meet regulatory requirements, and allows providers to manage their reimbursements.

For additional assistance, please access the Payspan website at payspanhealth.com/nps/Support/Index or contact Payspan via email at providersupport@payspanhealth.com or call 1-877-331-7154 Option 1.

6. Level of Care: Clinical Criteria, Service Providers and Authorization Requirements

Maryland PBHS

6.1 Level of Care

Optum Maryland maintains *Maryland PBHS Level of Care Appendix* (LOC Appendix) for both Mental Health and Substance Use Disorder Services that includes the following information, as applicable, by level of care:

- Who is eligible to receive the service
- Who is eligible to provide the service
- Eligibility reminders
- Authorization Reminders
- Service Reminders
- Billing Reminders

Please refer to the *Maryland PBHS Level of Care Appendix* for additional guidance and requirements related to level of care service and authorization requirements. This resource is accessible on the Optum Maryland website: maryland.optum.com > Behavioral Health Providers.

7. Medical Necessity and Care Delivery

Maryland PBHS

7.1 Participant Eligibility

For uninsured participants for whom Medicaid eligibility is anticipated, Optum encourages the provider to request a courtesy review. When medical necessity criteria are met and a courtesy review is on file, the provider will only need to submit a claim, if and when, the participant obtains Medicaid. If the participant remains in the hospital beyond the number of days initially authorized, the provider should request a courtesy review for the additional days.

When an uninsured eligible participant presents with a major illness that requires hospital level of care, the institution providing that care is expected to assist the family with an application for Medicaid.

7.2 Medical Necessity

The state of Maryland's Administrative Services Organization (ASO), Optum, will make clinical decisions about each participant based on the clinical features of the participant case, the medical necessity criteria, and the resources available.

Under the auspices of MDH, Optum bases its decisions on medical necessity. Medical necessity is met when a participant has a behavioral health disorder that requires professional evaluation and treatment, and the level of care provided is the least intensive, least restrictive level of care that is able to safely meet the participant's behavioral health and medical needs.

The State of Maryland designated Medical Necessity Criteria are:

- The State of Maryland Medical Necessity Criteria for mental health services maryland.optum.com.
- The ASAM Criteria for substance use disorders.

7.3 Description of Services

Please see section 6.1 of this manual and refer to the *Maryland PBHS Level of Care Appendix* for additional guidance and requirements related to level of care service descriptions. This resource is accessible on the Optum Maryland website: maryland.optum.com.

7.4 Authorization Process

Authorizations can be requested electronically through Incedo Provider Portal which can be accessed 24/7, including weekends and holidays through the Optum website: maryland.optum.com. Authorizations can also be requested telephonically by calling Optum at 1-800-888-1965.

Providers are expected to submit authorization requests, including clinical information supporting medical necessity criteria. Additional information or forms may be required based on the level of care being requested. Please see the *Maryland PBHS Level of Care Appendix* specific information for additional details.

Providers obtain additional authorizations through the electronic submission of a concurrent review request via Incedo Provider Portal. Concurrent requests should be submitted with supporting clinical information. See the *Maryland PBHS Level of Care Appendix* specific information for additional details.

Services provided to participants in an inpatient psychiatric or substance abuse unit are reviewed at the time of the initial request and may be reviewed concurrently by licensed Clinicians. These reviews provide information regarding the participant's status and need for continued care. Optum reserves the right to require a direct conversation with the attending psychiatrist before authorizing benefits for admission or continued stay.

If the Optum Care Advocate is not able to authorize the service as medically necessary, the request for services will be referred to an Optum Medical Director for review. If the services requested do not meet medical necessity criteria and are non-authorized, the determination of the non-authorized case will be communicated both via Incedo Provider Portal and telephonically to the provider (refer to Section 9, Grievances, Appeals and Complaints for further information).

7.5 Discharge Planning

Providers are expected to initiate aftercare/discharge planning at the beginning of service delivery or at the time of admission. Providers are also required to submit the aftercare/discharge plan as part of the authorization request. Providers are expected to work collaboratively with the participants, parents, legal guardians and/or identified proxies of participants to develop a discharge plan that will provide stability and adequate behavioral health treatment services.

When planning discharge from residential levels of care, providers should work with State Care Coordinators funded by the LBHAs or LLAs in the participant's county of residence to coordinate transition from residential to community services. Providers should be working towards linking consumers to outpatient level services and all needed social determinants (such as housing, community supports and employment) in the community throughout the residential stay.

7.6 Emergency Department Services

The rendering of emergency department (ED) services does not require pre-authorization.

ED service providers are expected to collect behavioral health and medical history, exchange information, and coordinate care with the participant's PCP and other treatment providers (e.g. substance use disorder treatment, mental health treatment, and other health providers) when clinically appropriate. If the participant in emergency circumstances is thought or known to be eligible for Maryland Developmental Disability Administration (DDA) services, the appropriate regional office of DDA should be contacted to arrange rapid evaluation (where available) and to delineate service options. This is a service reimbursable only for participants with Medicaid.

EDs regulated by the state of Maryland are eligible providers. Out-of-state EDs must be active Maryland Medicaid providers and have a signed provider agreement with Maryland Department of Health (MDH) in order to provide this service.

The Maryland Public Behavioral Health System (PBHS) does not cover services for participants presenting at an ED whose primary diagnosis is not a PBHS-covered diagnosis. A list of PBHS covered diagnosis is available at: maryland.optum.com.

Licensed providers requesting reimbursement from PBHS will also need their own active Maryland Medicaid individual or group number. The provider, NOT the hospital, will be paid for services rendered.

7.7 Physical Health Services While in a Psychiatric Hospital

The Managed Care Organization (MCO) is responsible for all non-psychiatric physician or nurse practitioner consultations which are not related to the psychiatric diagnosis.

7.8 Emergency Treatment and Active Labor Act (EMTALA)

When an uninsured participant who requires inpatient care presents at an emergency department of a psychiatric unit, the hospital must admit the participant to a bed on the hospital's psychiatric unit if available, or arrange for disposition to another inpatient setting as required under the Emergency Treatment and Active Labor Act (EMTALA). (Additional information is available on the Centers for Medicare and Medicaid Services (CMS) website: [cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index](https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index)).

The expectation is that participants will be admitted to these facilities without regard to ability to pay. If a person in need of psychiatric inpatient care is in an emergency department without a psychiatric unit, the emergency department will find the bed and refer the person for admission.

A participating hospital that has specialized capabilities, or facilities such as psychiatric hospitals, SHALL NOT refuse to accept an appropriate transfer of an individual (from a hospital in the United States) who requires such specialized capabilities or facilities IF the hospital has the capacity to treat the individual, 42 CFR §489.24(f). This provision applies to any participating hospital (those that accept Medicare and thus Medicaid) regardless of whether the hospital has a dedicated ED, §489.24(f)(i). The mental health service provider is expected to exchange information and coordinate care with the participant's primary care physician and other treatment providers (e.g. substance use disorder treatment) when clinically indicated, with appropriate release of information.

7.9 Gambling Services

As of January 1, 2018, reimbursement for problem gambling services is available to support assessment, individual and group therapy for persons with gambling disorders and/or loved ones/concerned others. This benefit is available to all residents of Maryland to receive these services at either their outpatient community Mental Health and Substance Use Disorder program or private practitioner.

Services are available to all Maryland residents, regardless of insurance coverage. This means

participants may be Medicaid eligible, Medicaid ineligible, uninsured or privately insured in the State of Maryland. Participants must also be a State of Maryland resident.

For additional information see Level of Care appendix.

7.10 Coordination for Individuals with Medical Care Providers and HealthChoice Managed Care Organizations (MCOs)

With the consent of the individual, the treating behavioral health provider(s) communicate directly with the medical care provider on a regular basis in order to coordinate behavioral health and medical health care. Interdisciplinary and interdepartmental conference calls, data sharing, treatment planning, and outreach to participants are all options for coordinating care on high-risk participants. To assist in this coordination of care, Optum also communicates with the HealthChoice Managed Care Organizations (MCOs) regarding high-risk participants with co-occurring behavioral health conditions and medical disorders.

To better serve the individual and the providers, Optum is available to play a role in treatment and recovery plans developed to meet the needs of individuals. Optum will also coordinate with other agencies such as the Department of Human Services, Department of Social Services (DSS), Department of Juvenile Services (DJS), Development Disabilities Administration (DDA), Maryland State Department of Education (MSDE), Behavioral Health Administration (BHA), Medicaid, Core Service Agencies (CSAs), Local Behavioral Health Authorities (LBHAs) and Local Addictions Authorities (LAAs) on an as needed basis. Pharmacy data is integrated into Incedo Provider Portal and is available to assist providers in the development and coordination of the optimal care plan.

To further ensure that individuals are receiving the appropriate coordination of services, Optum will conduct both scheduled and unscheduled audits. Onsite audits by Optum include a review of medical records for evidence of coordination of behavioral health services and medical services.

7.11 Rare and Expensive Case Management

Rare and Expensive Case Management (REM) is a case management program for people who have rare and expensive diseases, the types of which are listed in COMAR 10.09.69.17. REM is carved out of HealthChoice. Individuals who are in REM are disenrolled from their MCO and become Medicaid, fee-for-service.

7.12 Coordination of Care for Individuals with Severe and Persistent Behavioral Health Disorders and Co-occurring Medical Disorders

Individuals with severe and persistent behavioral health disorders leading to frequent medical and/or behavioral health hospitalizations may require more intensive coordination efforts. These participants are identified, flagged, and tracked by Optum to facilitate coordination between hospitals and community-based behavioral health providers.

Referrals are received on an ongoing basis from Optum Care Managers, MCOs, CSAs, LAAs, LBHAs and providers, as well as from regular reports of multiple inpatient admissions. Once participants are identified and their treatment history is analyzed, they are flagged in Optum's care management system to track future utilization patterns. This allows Optum to involve

relevant stakeholders in the discharge, transition, treatment, and rehabilitation planning of their participants. When an individual is identified, Optum Care Managers notify the treating and/or requesting behavioral health providers regarding the high risk status of the participant. Optum also emails the participant's CSA and/or LAA daily regarding any new admission to inpatient services for these high-risk participants.

For cases that involve the highest risk participants, Optum has designated resources who provide intensive care management and coordination of care activities. The goal of providing these services is to improve care and reduce inpatient recidivism by pulling together relevant stakeholders to collaborate on the participant's aftercare plans. As part of this collaboration, Optum often completes a peer-to-peer consultation with the treating behavioral health provider to review the treatment and aftercare plans. The Optum MCO Liaison coordinates meetings with relevant parties either telephonically or in-person. This can include, but is not limited to, CSAs, LAAs, MCOs, behavioral health providers, and medical care providers, and are utilized to discuss a comprehensive and individualized approach to address the participant's behavioral health and medical care needs. Referrals for this program may be made by contacting the Optum MCO Liaison.

7.13 Care Manager Availability

Optum Customer Service representatives are available Monday through Friday from 8 a.m. to 6 p.m. Eastern Time (EST or EDT). In addition, Clinical Specialists are available after hours, seven-days a week, including holidays and weekends, to discuss urgent and emergent situations such as inpatient admissions, clinical benefit determinations and decisions, appeals, or any other questions about the care management process. You may contact Optum at 1-800-888-1965

7.14 Affirmative Incentive Statement

Care management decision-making is based only on the appropriateness of care as defined by The State of Maryland Medical Necessity Criteria for mental health services and The ASAM Criteria for substance use disorder services. Please see section 6.1 of this manual and refer to the *Maryland PBHS Level of Care Appendix* for additional guidance and requirements related to level of care service descriptions. This resource is accessible on the Optum Maryland website: maryland.optum.com > Behavioral Health Providers.

All level of care and coverage determination guidelines are intended to standardize interpretation and application of available benefits, including benefit exclusions or limitations and are on maryland.optum.com.

Optum expects all treatment provided to be outcome-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. Optum does not reward its staff, practitioners or other individuals for issuing denials of coverage or service care. Utilization management decision makers do not receive financial or other incentives that encourage decisions that result in underutilization of services.

8. Services for Participants Who are Deaf or Hard of Hearing

Maryland PBHS

8.1 Services for the Deaf and Hard of Hearing

Services under the Maryland Public Behavioral Health System (PBHS) are provided to individuals who are deaf or hard of hearing and who meet the eligibility for public behavioral health services. Optum can be reached through the TTY number at 1-866-835-2755 or by dialing 711 for Maryland Relay to place a call to Optum at 1-800-888-1965.

In some instances there may be a need for an American Sign Language (ASL) or other visual language interpreter in order for services to be rendered. An interpreter may be needed in the following instances:

- 1) **A participant is deaf or hard of hearing.** If the behavioral health professional selected by the participant is not proficient in ASL/other visual language interpretation, an interpreter can be secured in order for the participant to access services. The treating professional shall be reimbursed for the service at normal rates and the interpreting services shall be reimbursed.
- 2) **A participant is a minor and has parent(s) who is deaf or hard of hearing.** If the mental health professional selected for a minor is not proficient in ASL/other visual language interpretation, and the minor's parents are deaf or hard of hearing, an interpreter may be secured in order for the minor's parent(s) to participate in treatment with their child. The treating professional shall be reimbursed for the service at normal rates and the interpreting services shall be reimbursed.
- 3) **A provider is deaf or hard of hearing.** If the service provider is deaf or hard of hearing and needs an interpreter in order to communicate with the participant, family member, or group members participating in the services, interpreter reimbursement is also allowed.

8.2 Reimbursement

Providers **MUST** contact the CSA or LBHA of the participant's residence of record prior to interpreter service delivery. The CSA will pay for ASL or other visual language interpreting services. The Behavioral Health Administration (BHA) will adjust the CSA's contract accordingly if funding is not available under their existing contract.

Deaf Addiction Services at Maryland (DASAM) provides Interpreting services or treatment services for substance use disorder treatment for participants who are deaf or hard of hearing umaryland.edu/dasam/ phone 1-443-462-3416, (TTY) 1-443-462-3089.

Providers should also access the Office of the Deaf and Hard of Hearing (ODHH). (For additional information see odhh.maryland.gov/) They work as an advocacy group and are a resource for state and local agencies. The ODHH offers awareness training to increase knowledge about the accessibility of services, as well as technical assistance to government agencies that may have questions regarding communication access and constituent services.

8.3 Telehealth

Maryland Medicaid will reimburse services delivered via telehealth to a patient that is deaf or hard of hearing by any enrolled provider that is fluent in ASL. Unlike telehealth for patients who are not deaf or hard of hearing, the patient may be located in their home. The originating site must meet the technological requirements listed in COMAR 10.09.49. If the ASL fluent provider is enrolled in Maryland Medicaid, actively licensed, and permitted within scope of practice to use telehealth, the provider may act as a distant site provider. The provider may bill for services rendered via telehealth to the patient that is deaf or hard of hearing, using the GT modifier. As with all specialty behavioral health services, the distant site provider is required to have authorizations for all services delivered via telehealth.

More information, including the “Telehealth Program Manual,” can be found on the Maryland Medicaid Telehealth Program webpage: mmcp.health.maryland.gov/Pages/telehealth.aspx or you may send questions or comments by email to mdh.telemedicineinfo@maryland.gov.

9. Grievances, Appeals and Complaints

Maryland PBHS

9.1 Overview

A grievance is a request made for re-review of a previous medical necessity determination that resulted in a non-coverage determination of a service request. A participant or a provider/advocate, with participant’s consent, may request a grievance. This section outlines the grievance process for PBHS.

Optum Maryland provides one internal level of a grievance following an initial medical necessity review that resulted in a non-coverage determination of a service request. The Maryland Behavioral Health Administration (BHA) provides a second level grievance review. The Maryland Behavioral Health Administration (BHA) is the final authority for participants who are uninsured eligible. For Medicaid, the state of Maryland’s Office of Administrative Hearings (OAH) is the final authority and they may review the decision for Medicaid services at any stage. The timeframes for making the initial determination by Optum is one hour from time of request for post stabilization, 24 hours for an urgent request and 14 days for a non-urgent request. The timeframes for making reconsideration, grievance, and appeal determinations are listed in the applicable sections below.

9.2 Definition of Terms

TERM	DEFINITION
Administrative Non-Coverage Determination	Failure to meet administrative requirements set forth by the Public Behavioral Health System (PBHS) and the BHA, resulting in a denial or reduction of coverage. Examples include not obtaining prior authorization when it is required, not requesting continued authorization for existing services before the last authorized day of service, and termination of coverage/lack of eligibility.
Appeal	A formal process available to Medicaid recipients to request the OAH to review the decision.
Care Manager	A licensed clinical professional who works with Participants, health care professionals, physicians, and insurers to maximize and administer benefits of individuals served by the Maryland PBHS.
Clinical Service Non-Coverage Determination	A determination by an Optum Maryland Physician Advisor that the requested behavioral health services are not medically necessary.
Complaint	An expression of dissatisfaction with some aspect of the Maryland PBHS.

TERM	DEFINITION
Grievance	A process available to Medicaid recipients and uninsured eligible individuals to request a re-review of a non-coverage determination of requested services for reasons of medical necessity.
Non-Urgent Request	A request for continued acute inpatient services or any other service level other than a request for pre-authorization of an acute inpatient admission.
Participant	A Maryland Medicaid recipient, uninsured eligible individual, or the participant's legal guardian who requests behavioral health services. For this chapter of the provider manual, a parent of the child is considered the participant.
Physician Advisor	A board-certified psychiatrist who reviews authorization requests and performs medical necessity determinations.
Reconsideration	A request for a peer-to-peer review between the provider and an Optum Maryland Physician Advisor. This is available to the provider when the initial clinical non-coverage determination of service was conducted without the benefit of a peer-to-peer review. The reconsideration must be requested within 24 hours from the notification of the initial non-authorization.
Urgent Request	A request for pre-authorization for admission to an acute inpatient facility or a service level in which the participant or provider of service believes that waiting 24 hours for a decision would potentially be harmful to the participant.

9.3 Grievances

Grievance Review 1: Optum Maryland

The initial review of an authorization request submitted by a participant or a provider on behalf of a participant is completed by an Optum Care Manager. A Care Manager may only authorize service requests. When a Care Manager is not able to authorize benefits based on the information provided, the Care Manager may ask the provider for additional information. Upon receipt of the additional information, the Care Manager will authorize the services requested or suggest an alternative level of care based on the information provided. If the Care Manager is not able to authorize benefits for services as requested or negotiate an alternative, the Care Manager will refer the case to the Optum Maryland Medical Director or Physician Advisor.

A non-coverage determination of services results when the Optum Medical Director or Physician Advisor reviews a service request and cannot approve the request because it does not meet the medical necessity criteria established for that level of service.

Reconsideration

A participant, provider, or participant advocate (with the participant's consent) may request a reconsideration following a non-coverage determination that is completed without the benefit of a peer-to-peer review.

The reconsideration is a request for a peer-to-peer review between the provider and Optum Maryland. The reconsideration must be requested within 24 hours from the notification of initial denial. Optum will make the reconsideration decision within 24 hours or by close of next business day from when the reconsideration request was received. If the decision non-coverage decision for the service is affirmed, then Optum sends a non-coverage notification letter to the participant and provider. If the participant or provider continues to disagree with the non-coverage decision, then a request can be made to have the service request reviewed by another Optum Physician Advisor as a Grievance Review I. If the non-coverage determination of the service request is upheld, Optum sends a non-coverage determination notification letter to the participant and provider.

If the participant continues to disagree with the non-coverage determination decision, then a request can be made to have the service request reviewed by the BHA as a Grievance Review II. A participant with Medicaid has a final appeal, which is to the OAH.

Grievance Review 1 Timeframes

A Grievance Review 1 must be filed within 10 business days of the initial non-coverage determination of service or completion of the reconsideration process. The Grievance Review 1 is completed telephonically between an Optum Physician Advisor and the provider. The timeframes for making the Grievance Review 1 determination by Optum is 24 hours or by the close of the next business day for an urgent request and five calendar days for a non-urgent request.

- Direct contact with the provider is required in order to make timely decisions.
- If the provider is not available within the timeframe allotted, the provider or participant may request that Optum place the request on hold for up to 72 hours.
- The Optum Physician Advisor will make reasonable attempts to reach the provider.
- Optum may request documentation from the treatment record when the telephonic information is unclear or incomplete.
- If the Optum Physician Advisor concludes that services are medically necessary, Optum authorizes the requested service and forwards a Grievance Review 1 authorization letter to the participant and the provider within two business days. The authorization is also entered into Incedo Provider Portal and is available to the provider to view or download.
- If the Optum Physician Advisor concludes that the non-coverage determination or partial non-coverage determination is appropriate, Optum informs the provider of the decision and his or her grievance rights during the telephonic review. A Grievance Review 1 non-coverage determination letter that includes information about the next level of grievance available to the participant is sent to the provider and participant within two business days.

Grievance Review 2 – BHA

A Grievance Review 2 must be requested in writing to BHA within 10 business days after the receipt of a Grievance 1 non-coverage determination decision. To file a Grievance Review 2 with BHA by mail, use the following address:

Behavioral Health Administration
Attn: Grievances and Appeals
Spring Grove Hospital Center – Dix Building
55 Wade Avenue
Catonsville, MD 21228

The Grievance Review 2 will be completed within five business days for an urgent request or within 10 business days for a non-urgent request.

- BHA may refer the grievance to Optum for re-review when grievance levels have not been used.
- BHA's review process may include input from the CSA, LBHA, or LAA as needed.
- BHA will notify the participant and provider, in writing, of the outcome to all grievances.
- BHA is the final authority for participants who are uninsured eligible. However, Medicaid recipients will be informed by BHA of their rights to appeal to the OAH.

9.4 Appeals

If a Medicaid participant wishes to appeal the BHA's decision, he or she must file a notice in writing to the Office of Health Services within 90 business days of BHA's decision to not authorize services. Request for appeal hearings should be submitted by mail to:

Maryland Department of Health Office of Health Services
Attention: Appeals Coordinator
201 West Preston Street, Room 127
Baltimore, Maryland 21201

The appeals coordinator will receive the materials and transmit the request to the Office of Administrative Hearings, an independent State agency.

9.5 Administrative Denials

An administrative non-coverage determination occurs when a claim is denied due to one of the following reasons:

- The provider fails to obtain a pre-authorization when required
- The timely filing requirements are not met
- Services are provided by a provider who is not participant in the primary coverage carrier's network
- The participant is not a Medicaid beneficiary

You have 90 days from the date of the notice of the administrative denial to contact Optum Maryland for a reconsideration of the denial based on documentation from the provider that the denial was made in error. To contact the Optum Grievances and Appeals Department, call 1-800-888-1965. To submit the required documentation showing the administrative denial was due to an error on the part of Optum, you can:

- Fax to: 1-844-913-0799
- Mail to:
Optum Maryland
Attn: Grievances and Appeals Department
P.O. Box 30532
Salt Lake City, UT 84130

9.6 Complaints

If you are unhappy with Optum Maryland or PBHS, you may tell us about it. If your concern is about anything other than a non-coverage determination or denial, you may file it as a complaint.

You may also file a complaint on behalf of a participant (with participant's consent).

There is no deadline for filing a complaint. You may file a complaint at any time.

You may file a complaint verbally or in writing. You may file your complaint in any of the following ways:

- Call the Optum Complaints Coordinator weekdays from 8 a.m. to 5 p.m. at 1-800-888-1965 or TTY at 711
- Mail your written complaint to Optum at:
Optum Maryland – Complaints
10175 Little Patuxent Parkway
Columbia, MD 21044

If you need help filing your complaint, call Optum at 1-800-888-1965, weekdays between 8 a.m. and 5 p.m.

Optum will send you a letter within five days of receiving your complaint to let you know that we received it.

Your complaint will be investigated, and in most cases, you will be advised of the outcome of that investigation within 30 calendar days of filing your complaint.

Sometimes Optum is not able to give the details about complaint outcomes to Participants and/or Providers. If Optum is not able to give you these details, we will tell you in the first letter we send you.

If you are not satisfied with the resolution of your complaint, you may request a resolution review. Instructions for this will be included in the resolution letter.

10. Provider Audits

Maryland PBHS

10.1 Site and Record Audits

Providers who participate in the Maryland Public Behavioral Health System (PBHS) are subject to announced and unannounced audits by Optum. Providers must be in compliance all applicable state and federal regulations, including COMAR 10.09.36 and COMAR 10.09 associated with the service(s) rendered.

Optum will perform audits on PBHS programs including:

- Individual practitioners
- Group practitioners
- Inpatient hospitals
- Residential treatment centers
- Substance use disorder programs and providers
- Community mental health program providers
- Other licensed or approved programs, as directed

Audits may include, but are not limited to, a review of any of the following:

- Physical environment
- Staffing
- Documentation, including consents, uninsured eligibility documentation, assessments, treatment plans, and contact/progress notes
- Evaluation of service delivery
- Billing records

Providers may be selected for an audit based on random selection, unusual service patterns, billing outliers, high utilization, need to evaluate overall service delivery, at the recommendation of BHA and/or Medicaid or practice patterns that may constitute fraud, waste, or abuse. Optum uses audit tools approved by Medicaid and the Behavioral Health Administration (BHA). The audit tools can be found at: maryland.optum.com

Upon completion of an audit, Optum will issue a report to be shared with the provider, BHA, Medicaid, and, as required, MDH. Office of the Inspector General and Office of the Attorney General/Medicaid Fraud Control Unit.

Reports detail audit findings, billing retraction amounts and best practice recommendations. Providers are required to submit a program improvement plan for audit areas with less than 85 percent compliance rate.

If potentially fraudulent or unethical behavior is identified or reported, providers will be referred to the appropriate State enforcement entity. Audits resulting in State disciplinary action or a program improvement plan may require close monitoring by Optum or the local behavioral health authority, and may be subject to additional audits.

11. Lab Services

Maryland PBHS

11.1 Lab Services: Substance Use Disorder (SUD) Service Providers

NOTE: Refer to section 2.3 Provider Types (PT) in this manual. PT 32, 54, 55, and PT 50 IOP (ASAM Level 2.1) and PHP (ASAM Level 2.5) programs must have contracts with independent labs (PT 10) and these services are not payable through the ASO, Optum Maryland..

Drug testing should be used as needed to improve outcomes, and should be integrated into the process of making treatment decisions.

Clinicians treating individuals who are at risk for or have a previous SUD diagnosis should do **random testing, be aware of the most prevalent drugs within the community, and order only those tests which are medically indicated.**

- On site CLIA-waived tests, which provide immediate results, should be rapidly integrated into treatment decisions and clinical assessments.
- Ordered tests should match **individualized treatment needs**. In the clinical setting, this would correlate with more **frequent testing during initial phase of treatment** or during relapse, followed by less frequent random tests when medically indicated by the individual's recovery progress.
- When ordering drug toxicology tests, it is important to know exactly how many drugs are being tested. The **number and types of tests ordered should match the number and types of tests on the results.**

PT 50 ASAM Level 1 (with a Category of Service (COS) = LA) may bill the ASO for medically necessary lab tests (presumptive lab test). Approved tests can be found in the fee schedule located at maryland.optum.com. If medically necessary, PT 50 can send appropriate lab requests to a PT 10 for a definitive test. Maryland Medicaid covers G0480 and G0481 (see fee schedule). Providers should follow the guidelines of ASAM SMART testing.

Independent providers must also have a COS = LA on their provider file in order to bill presumptive SUD lab services.

11.2 Lab Services: Mental Health Providers

The Maryland Public Behavioral Health System (PBHS) will reimburse laboratories that are in compliance with COMAR 10.09.09 for medically necessary tests and procedures related to psychiatric treatment rendered to Medicaid recipients by psychiatrists in the PBHS network. The laboratory must have a valid Maryland license and be Clinical Laboratory Improvement Amendment (CLIA) certified.

12. Pharmacy and Transportation

Maryland PBHS

12.1 Pharmacy Information

Pharmacy Network

Participants with Medicaid should use the pharmacy network and the pharmacy card they received from their Managed Care Organization (MCO) at the time of enrollment. Participants who do not belong to an MCO should use their Medicaid cards. Participants do not need to carry a separate card or use a different pharmacy network for their SUD or mental health medications.

Participants without Medicaid may contact their CSA, LBHA or LAA to inquire about pharmacy assistance or other help that may be available.

Additional information regarding the Medicaid Pharmacy benefit may be accessed at Maryland Department of Health: [Medicaid Pharmacy Program](#)

Medication Coverage

The Maryland Medicaid Pharmacy Program (MMPP) has a Preferred Drug List (PDL). Substance use disorder (SUD) medications are part of this program. The PDL is posted on the MMPP website at Maryland Department of Health: mmcp.health.maryland.gov/pap/Pages/Preferred-Drug-List.aspx

Some medications, including some SUD medications, require prior authorization due to quantity limits and/or clinical criteria, which are measures to encourage the safe and appropriate use of a drug. Medications that have quantity limits and/or clinical criteria are available at:

- Quantity Limits: [Maryland Medicaid Pharmacy Program Quantity Limits](#)
- Clinical Criteria: [Medicaid Pharmacy Program - Clinical Criteria](#)

12.2 Transportation

For Medicaid recipients, transportation to appointments for medically necessary ambulatory treatment services is primarily the responsibility of the local health department. Transportation services for Medicaid recipients will be based on the closest, willing provider.

Transportation is included in the rate of reimbursement under the Maryland Public Behavioral Health System's (PBHS) fee-for-service payment for participants in a psychiatric rehabilitation programs (PRPs), residential programs for pregnant women and children, or substance use services that are court ordered under Health General §8-507.

If an ambulance is called for a behavioral health emergency involving a Medicaid recipient, the ambulance provider must bill Medicaid directly. Ambulance services are not authorized through Optum and the claim should not be sent to Optum.

In accordance with Health General Article 10-628 for reimbursement of services provided under the emergency petition process, the Maryland Behavioral Health Administration (BHA) will pay for transportation of an individual by a public safety officer, to an emergency facility for an emergency evaluation if the individual is uninsured or their insurance does not cover this. If, after evaluation by a physician, the individual is verified for an involuntary admission, BHA will reimburse the transportation from the community hospital's emergency department to the receiving hospital that has been identified to accept that person as an involuntary admission. In these two instances, Optum may be billed for transportation. However, if an individual is subsequently found to have private insurance, the ambulance service bill shall be paid by the private insurance carrier. For costs requested for transportation reimbursement under the emergency petition process, Optum shall be provided a bill and documentation of services.

13. Claim Submission

Maryland PBHS

13.1 Overview

This section includes *13.2 General Claim Submission Guidelines* and a link to the *Maryland PBHS Provider Billing Appendix* (Billing Appendix) which Optum Maryland maintains. The Billing Appendix provides additional guidance and requirements for billing of specific services.

You may link to the [Maryland PBHS Provider Billing Appendix](#).

13.2 General Claim Submission Guidelines

Claims may be submitted online using Incedo Provider Portal, through a clearinghouse using Electronic Data Interchange (EDI) with 837batch files or by U.S. Mail.

Online and Electronic Claim Submission

For Incedo Provider Portal: After logging into Incedo Provider Portal, use the Incedo Provider Portal user Guide for instructions on entering a claim or for submitting an electronic file of claims. The link to the Incedo Provider Portal guide is found at [maryland.optum.com](#) > Behavioral Health Providers.

For EDI/Electronic claims: Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a payer. You may choose any clearinghouse vendor to submit claims using EDI. For PBHS claim submissions, use **Payer ID OMBDH**. The link to the 837i and 837p companion guides is [maryland.optum.com](#).

Paper Claim Submission

For U.S. Mail: Optum Maryland will accept current versions of paper Form-1500 forms for practitioner/professional services or Uniform Billing (UB)-04 forms for inpatient and outpatient facility claims. The mailing address for completed claim forms and required attachments is:

**Optum Maryland
PO Box 30531
Salt Lake City, UT 84130**

Please see section Paper claim submission for more specific instructions for Form-1500 and UB-04 claim forms.

Customer Service Claims Help

Optum Maryland has a dedicated customer service department with staff available five days a week during regular business hours to assist you with questions related to general information, eligibility verification or the status of a claim payment. You may also visit Incedo Provider Portal to gather claim status information.

The Optum Maryland customer service phone number is: **1-800-888-1965**.

General Guidelines – Outpatient Professional Claims Submitted on Form-1500

The provider shall submit claims using the current Form 1500 with applicable coding including, but not limited to, ICD-10, CPT, and HCPCS coding. The provider shall include on the claim the participant MA number or other participant identifier, provider's Federal Tax I.D. number, National Provider Identifier (NPI) as specified below and/or other identifiers requested by Optum Maryland.

- Form-1500 claim submission may not span dates. Submit each date of service on a separate line.
- Allowable HCPC and CPT codes are found on the Optum Maryland Covered Services Grid at maryland.optum.com.
- Authorization rules based on Level of Care information are found on the Optum Maryland Covered Services Grid at maryland.optum.com. Claims will be denied if the service requires an authorization and an authorization has not been issued.
- Multiple units of the same service code/modifier on the same day must be submitted on ONE claim line.
- Certain provider types require that a Rendering provider must be referenced on the claim. At the time of implementation, these include Provider Types: Mental Health Groups (PT 27), Physician Groups (PT 20), FQHC (PT 34), ABA (PT AB), and Outpatient Mental Health Centers (PT MC).

General Guidelines – Facility or Institutional Claims Submitted on UB-04

The provider shall submit claims using a UB-04 claim form for Facility-based claims, with applicable coding including, but not limited to, ICD-10 (or successor) diagnosis code(s), CPT, Revenue and HCPCS coding.

- UB-04 outpatient claims may not span dates. Submit each date of service on a separate line.
- Allowable HCPC and revenue codes are found on the Optum Maryland Covered Services Grid at maryland.optum.com.
- Authorization rules based on Level of Care information are found on the Optum Maryland Covered Services Grid at maryland.optum.com. Claims will be denied if the service requires an authorization and an authorization has not been issued.

- Bill Types must match the Facility Type. Bill types are provided after the Paper Claim instructions, refer to the Billing Appendix
- Rendering provider and attending provider are required on all claims.
- Inpatient claims may not span the State Fiscal Year (June to July). A separate claim must be submitted. Optum Maryland will deny claims that span the months June to July.

Refer to the [Maryland PBHS Provider Billing Appendix](#) for additional billing guidance and requirements.

14. Outcomes Data and Federal Reporting

Maryland PBHS

14.1 General Information

The approach to capture and report outcomes measures along with federally required data elements is under revision with the implementation of Optum Maryland as the ASO effective January 2020. Revisions to this guide will be published when the measures and associated reporting capability are established.

15. Manual Updates and Governing Law

Maryland PBHS

15.1 Manual Updates

This manual may be updated periodically as procedures are modified and enhanced. Providers will be notified a minimum of thirty (30) calendar days prior to any material change to the manual **unless** otherwise required by applicable law, regulatory or accreditation bodies. The current version of the manual is always available on the Optum Maryland website.

15.2 Governing Law and Contract

The *Maryland PBHS Provider Manual* applies to Medicaid recipients and eligible uninsured individuals served by the PBHS. It shall be governed by, and construed in accordance with applicable federal, state and local laws, and current MDH transmittals or alerts.