MedStar Family Choice

MedStar Family Choice Maryland HealthChoice Provider Manual

December 2025

HealthChoice Provider Manual Table of Contents

I. INTRODUCTION

A. Medicaid and HealthChoice

HealthChoice is the name of Maryland Medicaid's managed care program. There are approximately 1.7million Marylanders enrolled in Medicaid and the Maryland Children's Health Program. With few exceptions Medicaid beneficiaries under age 65 must enroll in HealthChoice. Individuals that do not select a Managed Care Organization (MCO) will be auto-assigned to an MCO with available capacity that accepts new enrollees in the county where the beneficiary lives. Individuals may apply for Medicaid, renew their eligibility and select their MCO on-line at **MarylandHealthConnection.gov** or by calling **855-642-8572** (TYY: **855-642-8572**).

Members are encouraged to select an MCO that their PCP participates with. If they do not have a PCP, they can choose one at the time of enrollment. MCO members who are initially auto- assigned can change MCOs within 90 days of enrollment. Members have the right to change MCOs once every 12 months. The HealthChoice program's goal is to provide patient-focused, accessible, cost-effective, high quality health care. The State assesses the quality of services provided by MCOs through various processes and data reports. To learn more about the State's quality initiatives and oversight of the HealthChoice Program go to: **https://health.maryland.gov/ mmcp/healthchoice/Pages/Home.aspx.**

Providers who wish to serve individuals enrolled in Medicaid MCOs are now required to register with Medicaid. MedStar Family Choice also encourages providers to actively participate in the Medicaid fee-for service (FFS) program. Beneficiaries will have periods of Medicaid eligibility when they are not active in an MCO. These periods occur after initial eligibility determinations and temporarily lapses in Medicaid coverage. While MCO providers are not required to accept FFS Medicaid, it is important for continuity of care. For more information, go to **https://eprep.health.maryland.gov/sso/login.do?**. All providers must verify Medicaid and MCO eligibility through the Eligibility Verification System (EVS) before rendering services.

We do not prohibit or otherwise restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is their patient.

B. Introduction to MedStar Family Choice

MedStar Family Choice is a provider-sponsored managed care organization comprised of over 5,000 providers associated with MedStar Health. MedStar Family Choice is part of MedStar Health, the largest health system in the Maryland/DC corridor. Currently, MedStar Family Choice has members throughout Baltimore City, Baltimore County, Harford County, Anne Arundel County, Calvert County, Charles County, St. Mary's County, Prince George's County, and Montgomery County. MedStar Family Choice is dedicated to building the type of integrated system necessary to deliver effective, high quality health care. MedStar Family Choice believes that by offering physicians the appropriate managerial and systems support MedStar Family Choice will be able to help them do what they do best, practice medicine.

All providers must be credentialed in the MedStar Family Choice network before seeing MedStar Family Choice members. Please contact Provider Relations at **800-905-1722, option 5** to obtain an application. MedStar Family Choice complies with NCQA guidelines and Maryland State law.

MedStar Family Choice accepts the Maryland Uniform Credentialing application for participation and also participates in CAQH. All providers are credentialed within the timeframes established under Maryland law.

If you have any questions about MedStar Family Choice, or the information contained in this manual, please do not hesitate to contact Provider Relations at **800-905-1722, option 5**.

C. Member Rights and Responsibilities

a. As a HealthChoice member, you have the right to:

- Receive health care and services that are culturally competent and free from discrimination.
- Be treated with respect to your dignity and privacy.
- Receive information, including information on treatment options and alternatives, regardless of cost or benefit coverage, in a manner you can understand.
- Participate in decisions regarding your healthcare, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of your medical records and request that they be amended or corrected as allowed.
- Request copies of all documents, records, and other information free of charge that was used in an adverse benefit determination.
- Exercise your rights, and that the exercise of those rights does not adversely affect the way the Managed Care Organizations (MCO), their providers, or the Maryland Department of Health treat you.
- File appeals and grievances with a Managed Care Organization.

- File appeals, grievances, and State fair hearings with the State.
- Request that ongoing benefits be continued during an appeal or state fair hearing; however, you may have to pay for the continued benefits if the decision is upheld in the appeal or hearing. Receive a second opinion from another doctor within the same MCO, or by an out-of-network provider if the provider is not available within the MCO, if you do not agree with your doctor's opinion about the services that you need. Contact your MCO for help with this.
- Receive other information about how your Managed Care Organization is managed including the structure and operation of the MCO as well as physician incentive plans. You may request this information by calling your Managed Care Organization.
- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Make recommendations regarding the organization's member rights and responsibilities policy.

b. As a HealthChoice member, you have the responsibility to:

- Inform your provider and MCO if you have any other health insurance coverage.
- Treat HealthChoice staff, MCO staff, and health care providers and staff, with respect and dignity.
- Be on time for appointments and notify providers as soon as possible if you need to cancel an appointment.
- Show your membership card when you check in for every appointment. Never allow anyone else to use your Medicaid or MCO card. Report lost or stolen member ID cards to the MCO.
- Call your MCO if you have a problem or a complaint.
- Work with your Primary Care Provider (PCP) to create and follow a plan of care that you and your PCP agree on.
- Ask questions about your care and let your provider know if there is something you do not understand.
- To understand your health problems and to work with your provider to create mutually agreed upon treatment goals that you will follow.
- Update the State if there has been a change in your status.
- Provide the MCO and their providers with accurate health information in order to provide proper care.
- Use the emergency department for emergencies only. Tell your PCP as soon as possible after you receive emergency care.
- Inform your caregivers about any changes to your Advance Directive.

c. HIPAA and Member Privacy Rights

MedStar Family Choice provides all new members a copy of its Notice of Privacy Practices upon joining MedStar Family Choice. A copy of the notice is also available on our website at **MedStarFamilyChoiceMD.com/privacy-Practices.** Provider Relations can provide copies of this notice upon request.

The notice outlines how MedStar Family Choice may use and disclose our member's information and when authorization for use and disclosure is required.

MedStar Family Choice has appropriate policies and procedures in place to make sure that our member's protected health information is safeguarded. These policies explain how MedStar Family Choice protects verbal and written, electronic protected health information (including mobile devices).

To ensure the privacy and security of its members' medical information, MedStar Family Choice requires its providers to abide by several medical record documentation standards. These standards include provisions such as:

- Providing a Notice of Privacy Practices to members.
- Compliance with all federal, state, and local regulations pertaining to medical records.
- Secure storage of both paper and electronic medical records.
- Standards to ensure confidentiality of member information.
- Release of information only to authorized staff, including those from MDH and HHS for quality assurance and auditing purposes and
- Reporting to MedStar Family Choice in a timeframe required by law, breaches of the HIPAA privacy rules as it relates to MedStar Family Choice members and cooperate with MedStar Family Choice in the remediation of such breaches.

Providers must report privacy breaches related to MedStar Family Choice members immediately in accordance with the Provider Agreement. Providers suspecting fraud and abuse must report this immediately by calling the MedStar Family Choice Director of Compliance or Provider Relations at **800-905-1722.**

d. Anti-Gag Provisions

Providers participating with MedStar Family Choice will not be restricted from discussing with or communicating to a member, enrollee, subscriber, public official, or other person information that is necessary or appropriate for the delivery of health care services, including:

1. Communications that relate to treatment alternatives including medication treatment options regardless of benefit coverage limitations.

2. Communications that are necessary or appropriate to maintain the provider-patient relationship while the member is under the Participating Physician's care.
3. Communications that relate to a member's or subscriber's right to appeal a coverage determination with which the Participating Physician, member, enrollee, or subscriber does not agree and
4. Opinions and basis of opinions about public policy issues.

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

e. Assignment and Reassignment of Members

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

- If they move to another county where MedStar Family Choice does not offer care.
- If they become homeless and find that there is another MCO closer to where they live or have shelter which would make getting to appointments easier.
- If they or any member of their family have a doctor in a different MCO and the adult member wishes to keep all family members together in the same MCO.
- If a child is placed in foster care and the foster care children or the family members receive care by a doctor in a different MCO than the child being placed, the child being placed can switch to the foster family's MCO or
- The member desires to continue to receive care from their primary care provider (PCP) and the MCO terminated the PCP's contract for one of the following reasons:
  - » For reasons other than quality of care.
  - » The provider and the MCO cannot agree on a contract for certain financial reasons or
  - » Their MCO has been purchased by another MCO.
  - » Newborns are enrolled in the MCO the birthing parent was enrolled in on the date of delivery and cannot change for 90 days.

Once an individual chooses or is auto-assigned to MedStar Family Choice and selects a primary care provider (PCP), MedStar Family Choice enrolls the member into that practice and mails them a member ID card. MedStar Family Choice will choose a PCP close to the member's residence if a PCP is not selected.

MedStar Family Choice is required to provide PCPs with their rosters on a monthly basis. MedStar Family Choice mails member rosters to PCPs on a monthly basis. This information changes daily and should not be used to determine member eligibility.

PCPs may see MedStar Family Choice members even if the PCP name is not listed on the

membership card. Members can call MedStar Family Choice Member Services Monday through Friday 8:30 a.m. to 5 p.m. at **888-404-3549** to change their PCP at any time.

As long as the member is eligible on the date of service and the PCP is participating with MedStar Family Choice, the PCP may see the MedStar Family Choice member. However, MedStar Family Choice does request that the PCP assist the member in changing PCPs so the correct PCP is reflected on the membership card. The office should contact Member Services **(888-404-3549)**. MedStar Family Choice's Member Services staff is available to providers Monday through Friday from 8:30 a.m. to 5 p.m to answer any eligibility or PCP questions.

f. Credentialing and Contracting with MedStar Family Choice

Becoming a Provider

MedStar Family Choice recognizes the importance of maintaining a provider network comprised of the necessary provider types to ensure that all of the covered health care benefits of our members our met. Our robust network of participating providers has afforded our members the convenience of seeing providers who are geographically accessible. Our network providers understand and are respectful of health-related beliefs, cultural values, and communication styles, attitudes, and behaviors of the cultures represented in the member population.

A provider directory will be available in print form and electronically via the website. Our provider relations staff will educate the provider network with regards to appointment time requirements and access to practitioners.

Initial Credentialing

All providers must have an active Maryland Medicaid Fee-for-Service Provider Number (rendering and Pay-To), which can be obtained through the Maryland Department of Health to be credentialed in the MedStar Family Choice network before providing covered services to MedStar Family Choice members. Providers interested in participating in the MedStar Family Choice Provider Network should contact the Provider Relations Department at **800-905-1722** Monday through Friday 8:30 a.m. to 5 p.m. to request contracts and an application package. If providers are participating with CAQH, providers may request the MedStar Family Choice Provider Relations department to send them a CAQH Data Form and Attestation for completion.

If providers are not participating in CAQH, the provider may use the paper Universal Credentialing Datasource (UCD) Application. This can be obtained on CAQH's website CAQH.org or can be obtained by contacting Provider Relations. The completed CAQH data form and signed and dated attestation or full paper application must be submitted to MedStar Family Choice for processing.

Signed participation agreements must accompany the CAQH form for the credentialing process to begin.

MedStar Family Choice complies with NCQA guidelines and guidelines outlined by MDH and Maryland law regarding credentialing and recredentialing timeframes.

The credentialing process is completed within the Maryland requirements upon receipt of a completed application and all required documents. Providers may contact the Provider Relations department for the status of their application. Providers will also be subject to a site audit if the office location is not currently recognized as an approved site in the network.

Each provider who applies for participation within the MedStar Family Choice Provider Network must provide documentation to satisfy the following criteria:

- A completed CAQH data form or CAQH credentialing application including a signed and dated attestation.
- MedStar Family Choice only recognizes residency programs accredited by the Accreditation Council for Graduate medical Education (ACGME) and the
- American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the royal College of Physicians and Surgeons of Canada.
- Completion of residency training (internship and residency) must include a minimum of at least three years for physicians.
- Current, valid, unrestricted license to practice medicine in the jurisdiction where they practice.
- Medical liability insurance coverage. Minimum liability amounts for MedStar Family Choice are $1,000,000 per claim, $3,000,000 per aggregate.
- Current unrestricted Drug Enforcement Agency (DEA) license and an unrestricted CDS license, if applicable.
- No current suspension, revocation, or limitation of licensure in any jurisdiction.
- No current sanctions by Medicare or Medicaid.
- Current, unrestricted privileges at one of the MedStar Family Choice participating hospitals.
- Specialists must be Board Certified or Board Eligible Qualified. Allied Health Care Professionals must be certified in their respective specialty.
- Participation (during credentialing or recredentialing) shall not be denied on the basis of practitioner's race, ethnic/national identity, gender, age, sexual orientation, religion, or any protected category under the federal Americans with Disabilities Act, or on the type of procedure or patient (e.g., Medicaid) in which the practitioner specializes. In addition, MedStar Family Choice does not discriminate against practitioners who specialize in conditions that require costly treatments, who serves high-risk populations, or who is acting within the scope of their license or certification under state law.

Credentialing for Nurse Practitioners and Physician Assistants

MedStar Family Choice requires credentialing for all providers who render services to our members including nurse practitioners and physician assistants. All providers rendering services must submit claims directly to MedStar Family Choice for processing and payment, utilizing their own Type I NPI as the rendering provider.

Recredentialing

MedStar Family Choice, in accordance with state and federal regulatory authorities, credentialing authorities, and other accrediting body (NCQA, CMS, etc.), requires recredentialing of providers at least every three years. If providers do not have a current and up to date CAQH record, or they do not participate with CAQH, the providers will be contacted several months prior to the actual reappointment date to begin the recredentialing process. Providers must have an active Maryland Medicaid Fee-For- Service provider number (rendering and Pay-To) at the time of recredentialing.

g. Provider Reimbursement

Payment to providers is in accordance with your provider contract with MedStar Family Choice or with their management groups that contract on your behalf with MedStar Family Choice 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.

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

h. Self-Referral and Emergency Services

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

The State allows members to self-refer to out of network providers for the services listed below. MedStar Family Choice will pay out of plan providers the State's Medicaid rate for the following services:

- Emergency services provided in a hospital emergency facility and medically necessary post-stabilization services.
- Family planning services excluding sterilizations.
- Maryland school-based health center services. School-based health centers are required to send a medical encounter form to the child's MCO. We will forward this form to the child's PCP who will be responsible for filing the form in the child's medical record. **See Attachment B for a sample School Based Health Center Report Form**. (Identified by place of service '03' on the claim.).
- Pregnancy-related services when a member has begun receiving services from an out- of-plan provider prior to enrolling in an MCO.
- Initial medical examination for children in state custody (identified by Modifier 32 on the claim).
- Annual Diagnostic and Evaluation services for members with HIV/AIDS.
- Renal dialysis provided at a Medicare-certified facility.
- The initial examination of a newborn by an on-call hospital physician when we do not provide for the service prior to the baby's discharge.
- Services performed at a birthing center.
- Children with special healthcare needs may self-refer to providers outside of MedStar Family Choice network under certain conditions. See Section II for additional information.

If a provider contracts with MedStar Family Choice for any of the services listed above the provider must follow our billing and preauthorization procedures. Reimbursements will be paid the contracted rate.

i. Maryland Continuity of Care Provisions

Under Maryland Insurance law HealthChoice members have certain continuity of care rights. These apply when the member:

- Is new to the HealthChoice Program.
- Switched from another company's health benefit plan or
- Switched to MedStar Family Choice from another MCO.

The following services are excluded from Continuity of Care provisions for HealthChoice members:

- Dental Services.
- Mental Health Services.
- Substance Use Disorder Services.
- Benefits or services provided through the Maryland Medicaid fee-for-service program.

Preauthorization for health care services

If the previous MCO or company preauthorized services, we will honor the approval if the member calls **800-905-1722.** Under Maryland law, insurers must provide a copy of the preauthorization within 10 days of the member's request. There is a time limit for how long we must honor this preauthorization. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health practitioner after the baby is born.

Right to use non-participating providers

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

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

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

If the member has any questions, they should call MedStar Family Choice Member Services at **888-404-3549** or the State's HealthChoice Help Line at **800-284-4510.**

II. Outreach and Support Services, Appointment Scheduling, EPSDT, and Special Populations

A. MCO Member Outreach and Support Services

Outreach Services

The Outreach Department contacts provider offices to obtain up-to-date member demographics, perform three-way calls to schedule appointments, confirm past/future appointments, and request medical records when needed. Members may be eligible to receive an incentive after completing a wellness visit. For a list of eligible wellness incentives, please visit **MedStarFamilyChoiceMD.com.**

The Outreach Department is available Monday through Friday 8:30 a.m. to 5 p.m. MedStar Family Choice can be reached at **800-905-1722** or **410-933-2200.** Providers may also fax MedStar Family Choice at **410-933-2232** or **888-991-2232.** Voice messages and faxes received after hours will be handled the next business day.

Appointment Scheduling and Outreach Requirements

In order to ensure that HealthChoice members have every opportunity to access needed health related services, PCPs must develop collaborative relationships with the following entities to bring members into care:

- MedStar Family Choice.
- Specialty care providers and
- The Local Health Department's Administrative Care Coordination Units (ACCU).

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

Non-Compliant Members

The MedStar Family Choice Outreach department assists providers in required outreach attempts for preventive care and member non-compliance. If providers are aware of non-compliant members, they may contact the Outreach department. The Outreach department contacts non-compliant members and works closely with the local health departments in an attempt to bring members into care. Providers should use the Outreach Referral Form and fax this completed form to **410-933-2232** or **888-891-2232.** If a provider continues to experience an issue with member non-compliance, the provider should contact Provider Relations. The Provider Relations department will provide the requirements that must be followed prior to requesting a member dismissal. Special at risk populations have specific guidelines surrounding referrals to the local health departments. Providers should be aware of referral guidelines surrounding these populations and ensure that members who miss appointments are referred to the outreach department and the local health department timely and appropriately.

B. State Non-Emergency Medical Transportation (NEMT) Assistance

If a member needs transportation assistance, contact the local health department (LHD) to assist members in accessing non-emergency medical transportation services (NEMT). MedStar Family Choice will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD. **See Attachment C for NEMT contact information**.

MCO Transportation Assistance

Under certain circumstances MedStar Family Choice may provide limited transportation assistance when members do not qualify for NEMT through the LHD.

Transportation Guidelines

MedStar Family Choice will assist in the coordination of transportation for members that meet the appropriate medical criteria. Please contact **800-905-1722** if a member requests transportation.

Requests for transportation can be made Monday through Friday from 8:30 a.m. to 5 p.m. The address, date, time, and telephone number of the appointment should be available. Transportation for routine care must be requested 5 to 7 days in advance. Urgent requests are an exception; however, MedStar Family Choice requests as much advance notice as possible. If the LHD will not provide transportation and the member meets the MedStar Family Choice transportation criteria, MedStar Family Choice will provide appropriate transportation. Our specific transportation criteria can be found on our website at **MedStarFamilyChoiceMD.com.**

C. State Support Services

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

D. Scheduling Initial Appointments

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

- You determine that no immediate initial appointment is necessary because the member already has an established relationship with you.
- For children under 21, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) periodicity schedule requires a visit in a shorter timeframe. For example, new members up to 2 years of age must have a well-child visit within 30 days of enrollment unless the child already has an established relationship with a provider and is not due for a well-child visit.
- For pregnant and postpartum members who have not started to receive care, the initial health visit must be scheduled and the members seen within 10 days of a request.
- As part of the MCO enrollment process the state asks the member to complete a Health

Services Needs Information (HSNI) form. This information is then transmitted to the MCO. A member who has an identified need must be seen for their initial health visit within 15 days of MedStar's Family Choice receipt of the HSNI.

- During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age appropriate physical exam.
- In addition, at the initial health visit, initial prenatal visit, or when a member's physical status, behavior, or laboratory findings indicate possible substance use disorder, you must refer the member to the Behavioral Health System at **800-888-1965.**

E. Early Periodic Screening Diagnosis and Treatment (EPSDT) Requirements

MedStar Family Choice will assign children and adolescents under age 21 to a PCP who is certified by the EPSDT/Healthy Kids Program. If member's parent, guardian, or caretaker, as appropriate, specifically requests assignment to a PCP who is not EPSDT-certified, the non-EPSDT provider is responsible for ensuring that the child receives well childcare according to the EPSDT schedule.

If you provide primary care services to individuals under age 21 and are not EPSDT certified call **410-767-1836.** For more information about the HealthyKids/EPSDT Program and Expanded EPSDT services for children under age 21 go to **https://health.maryland.gov/mmcp/epsdt/Pages/Home.aspx** Providers must follow the Maryland Healthy Kids/EPSDT Program Periodicity Schedule and all associated rules to fulfill the requirements under Title XIX of the Social Security Act for providing children under 21 with EPSDT services. The Program requires you to:

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

Members under age 21 are eligible for a wider range of services under EPSDT than adults. PCPs are responsible for understanding these expanded services. See Member Benefits in Section III. PCPs must make appropriate referrals for services that prevent, treat, or ameliorate physical, mental, or developmental problems or conditions.

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

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

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

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

EPSDT Outreach and Referral to LHD

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

- For children from birth through 2 years of age who miss EPSDT appointments and for children under age 21 who are determined to have parents, care givers or guardians who are difficult to reach, or repeatedly fail to comply with a regimen of treatment for the child, you should follow the procedures below to bring the child into care.
- Document outreach efforts in the medical record. These efforts should include attempts to notify the member by mail, by telephone, and through face-to-face contact.
- Schedule a second appointment within 30 days of the first missed appointment.

Within 10 days of the child missing the second consecutive appointment, request assistance in locating and contacting the child's parent, guardian, or caretaker by calling MedStar Family Choice at **800-905-1722.** You may concurrently make a written referral to the LHD ACCU by completing the Local Health Services Request form. **See Attachment D.** Continue to work collaboratively with MedStar Family Choice and the ACCU until the child is in care and up to date with the EPSDT periodicity schedule or receives appropriate follow-up care.

Support and outreach services are also available to members that have **impaired cognitive ability or psychosocial problems such as homelessness** or other conditions likely to cause them to have difficulty understanding the importance of care instructions or difficulty navigating the health care system. You must notify MedStar Family Choice if these members miss three consecutive appointments or repeatedly does not follow their treatment plan. We will attempt to outreach the member and may make a referral to the ACCU to help locate the member and get them into care.

F. Special Populations

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

- Pregnant and postpartum members.
- Children with special health care needs.
- Children in State-supervised care.
- Individuals with HIV/AIDS.
- Individuals with a physical disability.

- Individuals with a developmental disability.
- Individuals who are homeless.

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

- Demonstrate their credentials and experience to us in treating special populations.
- Collaborate with our case management staff on issues pertaining to the care of a special needs member.
- Document the plan of care and care modalities and update the plan annually.
- Individuals in one or more of these special needs populations must receive services in the following manner from us and/or our providers:
- Upon the request of the member or the PCP, a case manager trained as a nurse or a social worker will be assigned to the member. The case manager will work with the member and the PCP to plan the treatment and services needed. The case manager will not only help plan the care but will help keep track of the health care services the member receives during the year and serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and our case managers, when required, coordinate referrals for needed specialty care. This includes specialists for disposable medical supplies (DMS), durable medical equipment (DME), and assistive technology devices based on medical necessity. **PCPs should follow the referral protocols established by us for sending HealthChoice members to specialty care networks.**
- We have a Special Needs Coordinator on staff to focus on the concerns and issues of special needs populations. The Special Needs Coordinator helps members find information about their condition or suggests places in their area where they may receive community services and/or referrals. To contact the Special Needs Coordinator call **800-905-1722**.
- 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 must be referred to MedStar Family Choice If a member continues to miss appointments, call MedStar Family Choice at **800-905-1722.** We will attempt to contact the member by mail, telephone, and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the LHD ACCU. You may also make a written referral to the ACCU by completing the Local Health Services Request Form. See Attachment D or visit **https://health.maryland.gov/mmcp/docs/DHMH-4582-LHSRF-FRONT-PAGE-LHD-ACCU-10.10(web-only).pdf#search=Accu** The local ACCU staff will work collaboratively with MedStar Family Choice to contact the member and encourage them

to keep appointments and provide guidance on how to effectively use their Medicaid/ HealthChoice benefits.

Services for Pregnant and Postpartum Members

Prenatal care providers are key to assuring that pregnant members have access to all available services.

Many pregnant members will be new to HealthChoice and will only be enrolled in Medicaid during pregnancy and the postpartum period. Medicaid provides full benefits to these members during pregnancy and for one year after delivery after which they will automatically be enrolled in the Family Planning Waiver Program. For more information, visit: **https://health.maryland.gov/mmcp/familyplanning/Pages/Home.aspx** pregnancy-related services, which include:

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

The State provides these additional services for pregnant members:

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

Encourage all pregnant members to call the State's Help Line for Pregnant Woman at **800-456-8900.** This is especially important for members who are newly eligible or not yet enrolled in Medicaid. If the member is already enrolled in HealthChoice call us and also instruct them to call our MedStar Family Choice at **800-905-1722.**

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

The prenatal care providers must follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic, if possible, notice to member of the prenatal appointment dates and times. The prenatal care provider, PCP, and MedStar Family Choice are responsible for making appropri-

ate referrals of pregnant members to publicly provided services that may improve pregnancy outcome. Examples of an appropriate referral include the Women, Infants, and Children special supplemental nutritional program (WIC). Prenatal care providers are also required to:

- Provide the initial health visit within 10 days of the request.
- Complete the Maryland Prenatal Risk Assessment form-MDH 4850 during the initial visit and submit it to the Local Health Department within 10 days of the initial visit. MedStar Family Choice will pay for the initial prenatal risk assessment - use CPT code H1000.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- At each visit provide health education relevant to the member's stage of pregnancy. MedStar Family Choice will pay for this - use CPT code H1003 for "Enriched Maternity Services." You may only bill for one unit of "Enriched Maternity Services" per visit. Refer pregnant and postpartum members to the WIC program.
- If under the age 21, refer the member to their PCP to have their EPSDT screening services provided.
- Reschedule appointments within 10 days if a member misses a prenatal appointment. Call MedStar Family Choice if a prenatal appointment is not kept within 30 days of the first missed appointment.
- Refer pregnant members to the Maryland Healthy Smiles Dental Program. Members can contact Healthy Smiles at **855-934-9812;** TDD: **855-934-9816**;

  Web Portal: **Member.MDHealthySmiles.com** if you have questions about dental benefits.
- Refer pregnant and postpartum members in need of diagnosis and treatment for a mental health or substance use disorder to the Behavioral Health System; if indicated they are required to arrange for substance abuse treatment within 24 hours.
- Educate pregnant members to receive doula services or refer eligible members for home visits if medically necessary and appropriate.
- Record the member's choice of pediatric provider in the medical record prior to their eighth month of pregnancy.We can assist in choosing a PCP for the newborn.Advise the member thattheyshould be prepared to namethenewborn at birth.This is requiredforthe hospital to complete the "Hospital Report of Newborns", MDH 1184. (The hospital must complete this form so Medicaid can issue the newborns ID number.)The newborn will be enrolled in the postpartum member's MCO.

Childbirth Related Provisions

Special rules for length of hospital stay following childbirth:

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

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

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

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

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

If the member 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 within two (2) weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit. Breast pumps are covered under certain situations for breastfeeding members. Call us at **800-905-1722.**

Children with Special Health Care Needs

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

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

Established Member: A child who is already enrolled in MedStar Family Choice 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 member'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, members have an appeal right, regardless of whether they are a new or established member. Pending the outcome of an appeal, we may reimburse for services provided.

For children with special health care needs MedStar Family Choice will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions, social services, or both, a multi-disciplinary team must be used to review and develop the plan of care for children with special health care needs

- Refer special needs children to specialists as needed. This includes specialty referrals for children who have been found to be functioning one third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
- Allow children with special health care needs to access out-of-network specialty providers under certain circumstances. We log any complaints made to the State or to MedStar Family Choice about a child who is denied a service by us. We will inform the State about all denials of service to children. All denial letters sent to children or their representative will state that members can appeal by calling the State's HealthChoice Help Line at **800-284-4510.**
- Work closely with the schools that provide education and family services programs to children with special needs.

Children in State-Supervised Care

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

Individuals with HIV/AIDS

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

- An HIV/AIDS specialist is provided for treatment and coordination of primary and specialty care.
- A diagnostic evaluation service (DES) assessment can be performed once every year at the member's request. The DES includes a physical, mental, and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES for the evaluation.
- Substance use treatment is provided within 24 hours of request.
- The right to ask us to send them to a site doing HIV/AIDS related clinical trials. We may refer members who are individuals with HIV/AIDS to facilities or organizations that can provide the members access to clinical trials.

- 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 participant in receiving needed health care services.

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

Individuals with Physical or Developmental Disabilities

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

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

Homeless Individuals

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

G. Rare and Expensive Case Management Program

The Rare and Expensive Case Management (REM) Program is an alternative to managed care for children and adults with certain diagnosis who would otherwise be required to enroll in HealthChoice. If the member is determined eligible for REM they can choose to stay in MedStar Family Choice or they may receive services through the traditional Medicaid fee-for- service program. They cannot be in both an MCO and REM. **See Attachment A for the list of qualifying diagnosis and a full explanation of the referral process.**

III. HealthChoice Benefits and Services

A. MCO Benefits and Services Overview

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

Audiology Services

Audiology services will be covered by MedStar Family Choice for both adults and children. For individuals under age 21, bilateral hearing amplification devices are covered by the MCO. For adults 21 and older, unilateral hearing amplification devices are covered by the MCO. Bilateral hearing amplification devices are only covered for adults 21 and older when the individual has a documented history of using bilateral hearing aids before age 21.

Blood and Blood Products

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

Case Management Services

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

In addition to members designated by the state as a special needs population, case management services are available to all members of MedStar Family Choice. Direct referrals to our case management program are encouraged from multiple sources such as providers, as well as members themselves, and MFC will place the member in the appropriate level of services.

Per COMAR 10.67.04.04B, special needs populations are identified as 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 members.
- Individuals who are homeless.
- Individuals with HIV/AIDS.
- Children in State supervised care.

MedStar Family Choice Case Management Services are provided by nurses and social workers. These professionals assist members in the management of their complex bio-psycho- social needs. This is done by educating the member, facilitating access to healthcare, and connecting the member to needed resources within the community. The goal is that every member has the access to the care they need and they or their caregiver, is able to self- manage their health to the fullest of their capacity.

Case managers work closely with the provider to ensure that members receive appropriate and timely medical services. Our staff may contact you to collaborate, share clinical information or to verify that services were rendered. MedStar Family Choice case managers will forward you the Plan of Care for any of your patients enrolled in services and encourage your feedback.

Complex Case Management

Our Adult Complex Case Management Services are available to our highest risk level of adult members with complex conditions. This population includes members experiencing a critical event or diagnosis that requires care coordination or extensive use of resources.

- A critical event or diagnosis includes, but is not limited to the following:
  - Amyotrophic Lateral Sclerosis (ALS).
  - Hemophilia or Coagulation Disorders.
  - Lymphatic and Hematopoietic (blood) system disorders.
  - Guillain-Barre Syndrome.
  - Liver Failure.
  - Burns > 20% of total body surface area.
  - Hemiplegia.
  - Sickle Cell Disease with Severe Crisis.
  - Cancer/Tumors.
  - Cerebrovascular Accident (Stroke).
  - Sepsis.
  - Transplants.
  - COPD
  - CHF
  - Acute trauma with complex care coordination needs.
  - Complex psycho-social or behavioral needs complicating medical care.

Our Pediatric Complex Case Management Services are available to our highest risk level of pediatric members with complex conditions. This population includes members experiencing a critical event or diagnosis that requires care coordination or extensive use of resources.

- A critical event or diagnosis includes, but is not limited to the following:
  - Leukemia.
  - Hemiplegia.
  - Sickle Cell Disease.
  - Hemophilia.
  - Malignant Lymphoma.
  - Solid Tumor Metastatic.
  - Juvenile Rheumatoid Arthritis.
  - Epilepsy.
  - Transplants.
  - Acute trauma with complex care coordination needs.

- Pediatric members, or their guardians/caregivers, with complex psycho-social or behavioral health needs complicating medical care.

Comprehensive Care Programs

The Adult and Pediatric Comprehensive Care Programs are designed for those members who do not meet the eligibility requirements for the Complex Care Program and are identified

at our next highest level of risk. Criteria for inclusion at this level of care includes but is not limited to members with high utilization or reported to be at risk for high utilization due to diagnoses such as new onset of conditions or existing chronic conditions, who are identified as high or moderate risk by the risk stratification software.

- Conditions may include but are not limited to:
  - Diabetes.
  - Asthma.
  - Obesity.
  - Epilepsy.
  - Chronic Lung Disease.
  - Cardiovascular Disease (CAD).
  - Attention Deficit Hyperactivity Disorder (ADHD).
  - Depression.
  - Anxiety.
  - Substance use disorder.
  - Other Mood Disorder.

Condition Care

The Condition Care Program is designed for adult members who do not meet the requirements for higher levels of care management, but require additional assistance, health education, and care coordination in ongoing management of their chronic conditions(s), that include but are not limited to one of the following:

- Diabetes
- Asthma
- COPD
- Hypertension
- Cardiovascular Disease
- HIV
- Substance Use Disorder
- Social Issues/Mental Health

The aim of the Condition Care program is to promote self-management skills that prevent elevation into

a higher risk level. This is accomplished by assisting your patient to better understand their chronic condition, empowering them with self-care strategies, providing resources to manage their conditions, and reinforcing the mutually agreed upon treatment plan developed by you and your patient. As with any of the Case Management programs offered by MedStar Family Choice, the Case Management Staff may contact you to request clinical information, verify services that have been rendered or to collaborate on next steps. We do appreciate your prompt response to these requests.

High Risk Pregnancy

This program targets members who are at risk for poor birth outcomes. The program utilizes data mining reports as well as Maryland Prenatal Risk Assessments received from OB providers to identify members who are at risk for poor outcomes in current or future pregnancies. MFC uses multiple data sources to identify those pregnant members who are at greater risk for complications due to a history of prenatal complications and provide care coordination through the MFC High Risk Pregnancy program with the goal of maximizing outcomes for birthing parents and babies.

Transition Care Case Management Services

Transition Care Case Management is a service provided by MedStar Family Choice to assist your patient if they were just discharged from the hospital. Members of MedStar Family Choice do not have to enroll; they are identified by business rules that run within the clinical software used by MedStar Family Choice and utilize daily CRISP data. This service is provided by Registered Nurse Case Managers who work closely with your patient to assist with following the discharge plan order by the hospital care team, locating providers, and scheduling follow-up appointments. This service is offered for 30 days, and if after that time your patient requires further assistance, they will be referred to one of our other case management services.

Services offered to MedStar Family Choice members participating in Case Management Programs include:

- Support from our Case Managers and other staff to ensure that your patients receive the assistance they need to facilitate appropriate services.
- Educational materials, as appropriate, to understand their conditions.
- Assistance in coordinating homecare services as needed for skilled care, as well as any outstanding teaching needs.
- Information on community or MedStar Health events, such as health fairs or support groups that may be pertinent to their conditions.

Emergent Care Case Management Services

The Emergent Care Program is facilitated by non-licensed personnel under the guidance of the Manager of Case Management. It offers care coordination services to those members who exhibit a pattern of frequent ED utilization and is designed to reduce the likelihood of return ED encounters for services that could otherwise be provided by a PCP or urgent care center. Members are identified for the Emergent Care Program by business rules that run within the clinical software used by MedStar Family Choice and utilize daily CRISP data

Members participating in the Emergent Care Program who are found to require additional assistance upon program completion are referred for ongoing case management services as appropriate.

Members may also be offered in-home primary care intervention to address immediate needs, barrier analysis related to accessing care outside the ED, and assistance to re-connect care with a PCP.

Participation in Case Management

Member participation in any Case Management program is voluntary and members have the option to stop participating at any time. If providers would like to refer a member to one of these programs, please fax referral to **410-933-2209** or **855-855-2209,** or call the MedStar Family Choice Case Management Department at **410-933-2200** or **800-905-1722.** Any faxes or voice messages received after business hours will be handled the next business day.

Clinical Practice Guidelines for numerous medical conditions can be found on the MedStar Family Choice website. Copies can also be obtained upon request by calling our Care Management Department.

Clinical Trial Items and Services

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

Dental Services

The Maryland Healthy Smiles Dental Program (MHSDP) provides comprehensive dental services which include diagnostic, preventative, restorative, endodontic, periodontic, and certain prosthodontic services; oral maxillofacial surgery; and sedation.

Diabetes Care Services

We cover all medically necessary diabetes care services. For members who have been diagnosed with diabetes we cover:

- Diabetes nutrition counseling.
- Diabetes outpatient education.
- Diabetes-related durable medical equipment and disposable medical supplies, including:
- Blood glucose meters for home use.
- Finger sticking devices for blood sampling.
- Blood glucose monitoring supplies.
- Diagnostic reagent strips and tablets used for testing for ketone and glucose in urine and glucose in blood.
- Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear.

Diabetes Prevention Program

Members are eligible to participate in an evidence-based diabetes prevention program established by the Centers for Disease Control and Prevention if they:

- Are 18 to 64 years old.
- Overweight or obese.
- Have an elevated blood glucose level or a history of gestational diabetes mellitus.

- Have never been diagnosed with diabetes; and
- Are not currently pregnant.

Diagnostic and 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 by the State. See Section IV for additional information on information related to laboratory services that can be performed in a physician's office, pre- authorization and in network labs.

Dialysis Services

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

Disease Management

See Case Management services above.

Durable Medical Services and Durable Medical Equipment

We cover medically necessary DMS/DME services. We must provide authorization for DME and/ or DMS within a timely manner so as not to adversely affect the member's health and within two business days of receipt of necessary clinical information but not later than 14 calendar days from the date of the initial request. We must pay for any durable medical equipment authorized for members even if delivery of the item occurs within 90 days after the member's disenrollment from MedStar Family Choice as long as the member remains Medicaid eligible during the 90-day time period.

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

MedStar Family Choice routinely reviews billing guidelines for Durable Medical Services and Durable Medical Equipment. For more information related to this category of services, please see: Provider Resources for the most current policies.

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

We must cover EPSDT services listed below for members under 21 years of age.

Well-child services provided in accordance with the EPSDT/Healthy Kids 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 oral health screening; and
- Health education.

The State must also provide or assure the MCO provides expanded EPSDT services and partial or inter-periodic well-child services necessary to prevent, treat, or ameliorate physical, mental, or developmental problems or conditions. Services must be sufficient in amount, duration, and scope to treat the identified condition, and all must be covered subject to limitations only based on medical necessity.

These include such services as:

- Chiropractic services;
- Nutrition counseling;
- Private duty nursing services;
- Durable medical equipment including assistive devices; and
- Behavioral health services.

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

Family Planning Services

We will cover comprehensive family planning services, such as:

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

Gender-Affirming Services

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

Habilitation Services

We cover habilitation services when medically necessary for certain adults who are eligible for Medicaid under the ACA. These services include: physical therapy, occupational therapy, and speech therapy. If you have questions about which adults are eligible call **800-905-1722.**

Home Health Services

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

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

Hospice Care Services

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

Inpatient Hospital Services

We cover inpatient hospital services. MedStar Family Choice is not responsible for payment of any remaining days of a hospital admission that began prior to the individual's enrollment in our MCO. We are, however, responsible for reimbursement of professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

Mobile Integrated Community Health

We cover mobile integrated services provided by approved EMS agencies for eligible adults.

Outpatient Hospital Services

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

Outpatient Rehabilitative Services

We cover outpatient rehabilitative services including but not limited to medically necessary physical therapy for adult members. For members under 21 rehabilitative services are covered by MedStar Family Choice when the service is part of a home health visit or inpatient hospital stay.

Oxygen and Related Respiratory Equipment

We cover oxygen and related respiratory equipment.

Pharmacy Services and Copays

We are responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program.

We cover medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider. Most behavioral health drugs are on the State's formulary and are the responsibility of the State.

There are no pharmacy co-pays for children, pregnant members, Native Americans, individuals in nursing facilities or hospice, or birth control. For drugs covered by the State, such as behavioral health drugs, pharmacy copays are $1 for generic drugs, preferred brand name drugs, and HIV/ AIDS, and $3 for brand name drugs.

Co-pays and other insurance

Beginning on May 1, 2024, MedStar Family Choice is required by the Maryland Department of Health to have a copay (cost) for most prescription medicines.

- For most formulary (covered) brand name or generic medicines there is a copay (cost) of $1.00
- Some formulary (covered) brand medicines will have a copay (cost) of $3.00, these are marked as "Tier 2" on the formulary
- For HIV/AIDS medicine you will have a copay (cost) of $1.00.
- There is NO cost for family planning options (condoms, IUD, birth control pills, etc.).
- For non-formulary (non-covered) brand name medicines you will have a copay (cost) of $3.00.

Please note that the following MedStar Family Choice members will not have a copay for their medicine.

- Members under the age of 21
- Members who are pregnant people
- Members who are in hospice care (programs that give special care to people who are near the end of life and have stopped treatment to cure or control their illness/disease).
- Members who are Native Americans

Plastic and Restorative Surgery

We cover these services when the service will correct a deformity from disease, trauma, congenital or developmental anomalies, or to restore body functions. **Cosmetic surgery to solely improve appearance or mental health is not covered by the State or by the MCO.**

Podiatry Services

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

Pregnancy-Related Care (Services for Pregnant and Postpartum Members)

MedStar Family Choice 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);
- 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 birthing parent;
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant members;
- Appropriate levels of inpatient care, including emergency transfer of pregnant members and newborns to tertiary care centers;
- Postpartum home visits;
- Referral to the ACCU;
- Doula Support for prenatal visits, attendance at labor and delivery, and postpartum visits; Prenatal, postpartum, and infant home visits from pregnancy and childbirth up to two or three years of child's age.

Doula Services / Eligibility

- Services may be rendered from time of beneficiary enrollment into the program until eight (8) perinatal visits have been exhausted or up to one hundred-eighty (180) days after delivery, whichever comes first.
- A health care professional or MedStar Family Choice may refer a Member directly for Doula Services. A member may self-refer for Doula Services as well.

Home Visiting Services / Eligibility

- Be pregnant or infant must be younger than ninety (90) days old at the time of enrollment for HVS; and
- For NPF only, enrollment limited to individuals with no previous live births.
- A health care professional (i.e., physician, or other licensed clinician such as social worker, nurse practitioner, or local health department worker) or MedStar Family Choice may refer a Member directly for HVS. A member may self-refer for HVS as well.

Primary Behavioral Health Services

We cover primary behavioral health services, including assessment, clinical evaluation, and referral for additional services. The PCP may elect to treat the member, if the treatment, including visits for Buprenorphine treatment, falls within the scope of the PCP's practice, training, and expertise. Referrals for behavioral health services can be made by calling the State's ASO at **800-888-1965,** Monday through Friday, 8:00 a.m. to 6:00 p.m.

Primary Care Services

Primary care is generally received through a member'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 a member is eligible. In some cases, members 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 member's general health needs.
- Coordination of the member's health care.
- Disease prevention and promotion and maintenance of health.
- Treatment of illness.
- Maintenance of the member's health records and
- Referral for specialty care.

For female members, if their PCP is not a members' health specialist, they may see a member's health specialist within MedStar Family Choice, without a referral, for covered services necessary to provide member's routine and preventive health care services.

Skilled Nursing Facility Services

For members that were enrolled in MedStar Family Choice prior to admission to a skilled nursing facility, chronic hospital or chronic rehabilitation hospital and who meet the State's level of care (LOC) criteria, MedStar Family Choice is responsible for up to 90 days of the stay subject to specific rules.

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

A member's PCP is responsible for making the determination, based on our referral requirements, of whether or not a specialty care referral is medically necessary. PCPs must follow our special referral protocol for children with special 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 6 months.

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

Telemedicine and Remote Patient Monitoring

We must offer telemedicine and remote patient monitoring to the extent they are covered by the Medicaid Fee-for-Service Program.

Transplants

We cover medically necessary transplants to the extent that the service would be covered by the State's fee-for-service program.

Vision Care Services

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

MedStar Family Choice covers additional vision services for adults. We will cover:

- Exam/Frame: Members of all ages - once every 12 months based on a calendar year. Members through age 20 may receive more frequent exams if needed in accordance with EPSDT guidelines.
- Lenses: Members of all ages - two units every 12 months based on a calendar year.
- Replacement Frames and Lenses: Member through age 20, one replacement frame and 2 lenses are covered for lost, broken, stolen, irreparable beyond wear or are no longer usable due to a change in head size or anatomy. Prior authorization is required. A change in refractive error of a total refractive value of at least + / - 0.50 diopter in at least one eye to meet replacement criteria.
- Medically Necessary Contact Lenses: Covered for all Members, in lieu of eyeglasses and subject to prior authorization.
- The above routine vision benefits are administered through Avesis. They can be reached at **833-241-4248.**

B. Optional Services Covered by MedStar Family Choice

In addition to those services previously noted MedStar Family Choice currently provides the following optional services to our members. These services are not taken into account when setting our capitation rate. MCO optional services may change each Calendar Year. We may not discontinue or reduce these services without providing advance notification to State.

- **Over-the-counter medications -** See the MedStar Family Choice formulary or our website

for a complete and up to date listing of over the counter medications. In order for the MedStar Family Choice member to receive these medications, the provider must call the pharmacy with the order or write a prescription for the medication. MedStar Family Choice will not pay for the OTC medications without a physician's order. (The only exception to this is for the purchase of condoms. Condoms do not require a physician order.)

- **Transportation -** MedStar Family Choice will provide transportation when certain medical criteria are met.
- **24-Hour Nurse Advice Line**
- **Health Education Classes -** MedStar Family Choice members are able to sign up for a variety of health education classes that are sponsored by the MedStar Health hospitals. Class schedules are sent to members upon enrollment. In addition, schedules are sent to all PCP and OB/GYN offices on a regular basis. The latest listing of classes can also be found on the website. Please encourage MedStar Family Choice members to take appropriate classes that would be of benefit for their particular condition or disease.

  Providers that refer members to a health education class should document this in the member's chart. Members who wish to quit smoking are encouraged to call the QuitLine for immediate assistance (**1-800-QUIT-NOW**).
- **Interpreter Services -** MedStar Family Choice is committed to ensuring all members, regardless of their language or communication needs, can access the care they need. This guide highlights the language assistance available on our website, along with other resources to help providers and healthcare professionals support members with limited English proficiency or hearing/vision impairments. This guide may be shared directly with members to help them understand how to access these services and resources.
- **Website in Many Languages** – A Key Resource for Your Patients Our website offers important healthcare information in several languages, making it easier for members to understand their care options, benefits, and rights.
  - » Go to: **MedStarFamilyChoiceMD.com**
  - » Select a language from the dropdown menu in the top right corner of the homepage.
  - » All key content, such as member rights, benefits, and contact info, will be displayed in the chosen language.

    Encourage your patients to visit the website and use this resource to access translated information. This helps ensure they can make informed healthcare decisions.
- **Interpreter Help (Talking Services)** If a member needs to speak with someone in their preferred language, we provide telephonic or in-person interpretation:
  - » Phone Help: **Call 800-905-1722, option 1,** to help with appointments, care, or questions
  - » In-Office Help: Request an interpreter (in person, by phone, or video).
  - » Fill out the Interpreter Request Form
    - Email it to: **MFC-ProviderRelations2@MedStar.net**
    - Submit early to ensure availability.
- **Help with Medical Paperwork (Translation Services)** If a member needs help reading medical documents in their language:

  - » Send the form and medical document to: **MFC-ProviderRelations2@MedStar.net**
  - » You can also send both using the Interpreter Request Form.
- **MD Relay for Members with Hearing Impairments** For members who are deaf, hard of hearing, or have speech impairments, MD Relay is available to access interpreter services.
  - » MD Relay Number: 711 (this is a free service for TTY users, voice carry-over, and speech-to-speech services).
  - » Members can use their preferred method (TTY, voice, or video relay) to connect with MedStar Family Choice. For routine appointments, providers should give at least five (5) days prior notice for an interpreter request. For urgent appointments, providers must request assistance as quickly as possible.

For more information or to locate the form, visit the Interpretation/Translation Services page on our website: medstarfamilychoice.com.

C. Additional Services Covered by the State (Not by MedStar Family Choice)

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

D. Non-Covered Services and Benefit Limitations by the State

- Services performed before the effective date of the member's enrollment in the MCO are not covered by the MCO but may be covered by Medicaid fee-for-service if the member was enrolled in Medicaid;
- Services that are not medically necessary;
- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state);
- Services that are beyond the scope of practice of the health care practitioner performing the service;
- Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when a member is participating in an authorized clinical trial;
- Cosmetic surgery to improve appearance or related services, but not including surgery and related services to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental abnormalities;
- While enrolled in an MCO, services, except for emergency services, are not covered when the member is outside the State of Maryland unless the provider is part of MedStar Family Choice network. Services may be covered when provided by an MCO network provider who has obtained the proper referral or pre-authorization if required. If a Medicaid beneficiary is not in an MCO on the date of service, Medicaid fee-for service may cover the service if it is a covered benefit and if the out of state provider is enrolled in Maryland Medicaid;
- Services provided outside the United States;
- Immunizations for travel outside the U.S;
- Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis;
- Private hospital room is not covered unless medically necessary or no other room is available;
- Autopsies;
- Private duty nursing services for adults 21 years old and older;
- Orthodontia is not covered by the MCO but may be covered by Healthy Smiles when the member is under 21 and scores at least 15 points on the Handicapping Labio- lingual Deviations Index No. 4 and the condition causes dysfunction;
- Ovulation stimulants, in vitro fertilization, ovum transplants, and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar;
- Reversal of voluntary sterilization procedures;
- Medications for the treatment of sexual dysfunction;
- MCOs are not permitted to cover abortions. We are required to assist members in locating these services and we are responsible for related services (sonograms, lab work) but the abortion procedure, when conditions are met, must be billed to Medicaid fee-for service;
- 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 member is under 12 years old and 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;
- Diet and exercise programs for weight loss except when medically necessary;
- Lifestyle improvements (physical fitness programs and nutrition counseling, unless specified);MCOs do not cover emergency transportation services and are not required to cover non-emergency transportation services (NEMT). MedStar Family Choice will assist members to access non-emergency transportation through the local health department. We will provide some transportation if necessary to fill any gaps that may temporarily occur in our network. **See Optional Services in Section B.** 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:

COUNTY	TELEPHONE NUMBER TO CALL
ALLEGHANY	**301-759-5123**
ANNE ARUNDEL	**410-222-7152**
BALTIMORE CITY	PROBLEM RESOLUTION - **410-396-7007** ENROLLMENT AND SCHEDULING - **410-396-6422** FACILITIES AND PROFESSIONAL OFFICES - **410-396-6665**
BALTIMORE COUNTY	TRANSDEV - **410-783-2465** **410-887-2828**
CALVERT	**410-414-2489**
CAROLINE	**410-479-8014**
CARROLL	**410-876-4813**
CECIL	**410-996-5171**
CHARLES	**301-609-7917**
DORCHESTER	**410-901-2426**
FREDERICK	**301-600-1725**
GARRETT	GARRETT COMMUNITY ACTION - **301-334-9431**
HARFORD	**410-638-1671**
HOWARD	**877-312-6571**
KENT	**410-778-7025**
MONTGOMERY	**MONTGOMERY CO DEPT OF PUBLIC WORKS & TRANSIT - 240-777-5899**

COUNTY	TELEPHONE NUMBER TO CALL
PRINCE GEORGE'S	301-856-9555
QUEEN ANNE'S	443-262-4462 OR 410-758-0720 EXT 4462
ST. MARY'S	301-475-4296
SOMERSET	443-523-1722
TALBOT	410-819-5609
WASHINGTON	240-313-3264
WICOMICO	410-548-5142 OPTION #1
WORCESTER	410-632-0092 OR 0093

IV. Prior Authorization and Member Complaint, Grievance, and Appeal Procedures

A. Services Requiring Prior Authorization

In most cases, prior-authorization for routine specialty care is not required. Those services requiring prior-authorization are detailed in the most current Prior Authorization Quick Reference Guide available on our website, MedStarFamilyChoice.com under the Provider Resources tab.

MedStar Family Choice reviews services at least annually to determine if they need to be added to or removed from the list of services requiring prior authorization. Our goal is to continually look to streamline this process to reduce the amount of administrative work that our participating providers are required to do prior to services being rendered to our members. MedStar Family Choice will notify providers of any changes to the list of services requiring prior authorization no less than 30 calendar days prior to the effective date of the Prior Authorization list modification.

To obtain the most current list of services that require a prior authorization, please visit **MedStarFamilyChoice.com** and look in the "Maryland Providers" area, under "Provider Resources." Providers without internet access can call **800-905-1722, option 5** for additional assistance.

Prior Authorization Notes:

Out-of-Network care for non-Self Referral Services always requires a prior authorization. G**enetic counseling during pre-natal care must be performed by the OB/GYN.**

Newer Services: Doulas and Home Visiting Services

Coverage for doula and home visiting services for our pregnant population began in 2022.

While prior authorization is not required for doula services, please be advised MedStar Family Choice will implement use of the following forms for care coordination: Initial Screening and Doula Visit Note. These forms are to be completed and submitted to MedStar Family Choice within one (1) month from the start of care.

Home visiting services (HVS) will require the following forms for care coordination to be submitted within one (1) month from the start of care: Home Visiting Service Initial Screening and HVS Prenatal Visit Notes.

For HVS, prior authorization will be required for any visit beyond thirty (30) and no more than ten (10) visits will be authorized at a time.

Additional details are available online under Provider Resources at **MedStarFamilyChoiceMD.com.**

New Technology

MedStar Family Choice evaluates new technology on an as needed basis. Providers may contact the MedStar Family Choice Care Management department to request authorization for the new technology. One of the MedStar Family Choice Medical Directors will review the request and make sure that it has been approved by the Food and Drug Administration. In addition, we will determine if the service is covered by the Medical Assistance program. If it is covered under Medical Assistance, the request will be approved if it is medically necessary. If Medical Assistance does not currently cover the new technology MedStar Family Choice will review industry standards in considering whether or not to cover the new technology.

B. Services Not Requiring Preauthorization

- Procedures performed by an in-network provider at an in-network facility do not require prior authorizations.
- CT Scan, MRI's and Screening Mammograms performed at participating free-standing radiology site do not require prior authorization.
- Dialysis is a self -referred service and does not require prior authorization Providers are encouraged to refer members to a participating facility when possible.
- In most cases, prior-authorization for routine specialty care is not required. Those services requiring prior-authorization are detailed in the most current Prior Authorization Quick Reference Guide available on our website, **MedStarFamilyChoiceMD.com** in the Provider Resources section under the Maryland Providers section.

C. Prior Authorization Procedures

MedStar Family Choice follows a basic pre-authorization process: A member's physician forwards clinical information and requests for services to MedStar Family Choice by phone, fax, or infrequently by mail.

Providers may contact a case manager on business days from 8:30 a.m. to 5 p.m. at **410-933-2200** or **800-905-1722.** The fax number is **410-933-2274** and faxes are received 24 hours a day, seven days a week. Faxes and voice messages received after hours will be addressed the next business day. The after-hours voicemail message includes name and telephone number to contact for after hours needs. The message also contains a telephone number for MedStar Family Choice representatives to be contacted

for urgent pharmacy issues.

MedStar Family Choice does not specifically reward practitioners or other individuals for issuing denials of coverage of care. In addition, there are no financial incentives for Utilization Management (UM) decision makers that would encourage decisions that result in underutilization. Clinical practice guidelines for certain conditions can be found on the website.

Providers may also call the MedStar Family Choice Care Management department

to request a written copy. Providers may request the UM criteria utilized for a specific case by calling the MedStar Family Choice Care Management department at **800-905-1722.**

All appropriate ICD-10/CPT/HCPCS, along with supporting clinical information must be included in requests for pre-authorization. ICD-10/CPT/HCPCS codes in the medical record must match what is being requested for authorization and what is billed to MedStar Family Choice. Requests for authorization can be included on the Maryland Uniform Consultation Referral Form or MedStar Family Choice Prior Authorization Form with clinical information attached. MedStar Family Choice's experienced clinical staff reviews all requests.

MedStar Family Choice pre-authorization decisions are based on the following criteria:

- MedStar Family Choice Protocols.
- MedStar Family Choice Pharmacy Policies and Procedures.
- InterQual.
- Medicare and Medicaid Guidelines.
- Code of Maryland Regulations (COMAR).
- MedStar Family Choice MCO benefit coverage.
- MedStar Family Choice Provider Manual.
- MedStar Family Choice Member Handbook.
- Food and Drug Administration (FDA) Approval.
- Maryland Medicaid DMS/DME Program Approved List of Items.
- Availability of services within the MedStar Family Choice network.
- MedStar Family Choice Continuity of Care Policy.
- Pain Management Contracts.
- UM Criteria Policy.
- National and International Professional Medical Society Guidelines, including but not limited to:
  - National Comprehensive Cancer Network (NCCN).
  - NCCN Biomarkers Compendium.
  - National Institutes of Health.
  - National Cancer Institute.
- Maryland Medicaid Medical Laboratory and Professional Services Program Approval List of Items.

- US Preventative Task Force.
- Maryland Medicaid Audiology Services Fee Schedule.
- In the absence of guidelines, use prevailing medical literature form studies and journals.
- Maryland Medical Audiology Services Fee Schedule.
- HealthChoice Diabetes Prevention Program Manual.

MedStar Family Choice reserves the right to direct services to participating providers and facilities. Services outside the network are available only when they are not available within the network, for continuity reasons. MedStar Family Choice's utilization management decision making is based on the medical necessity of the service and the existence of MCO enrollment and coverage.

MedStar Family Choice requires up to two business days to process a complete, non-urgent authorization request. Requests are considered complete when all necessary clinical information is received from the requesting provider. The final decision cannot take longer than 14 days, whether or not all clinical information has been received. If the service requested is denied the provider may contact our Care Management department by calling **800-905-1722** to discuss the decision with the appropriate medical director.

For members with urgent authorization needs, physicians or a physician's staff member should contact MedStar Family Choice Care Management at **410-933-2200** or **800-905-1722.**

A decision regarding urgent authorizations will be made within 72 hours of receiving the request. A limited number of services require authorization from MedStar Family Choice Care Management before the patient receives care. Retrospective requests are reviewed against the above specified criteria and are not guaranteed approval. Retrospective services that could have been provided within the network are not likely to be retrospectively approved unless upon review the care was urgent/emergent, a COMAR defined self-referral service or a continuity of care.

Services that are carved out to the State of Maryland Medicaid, which include, but are not limited to pediatric outpatient rehabilitation services and behavioral health care, are subject to administrative denial since they are not the liability of MedStar Family Choice.

D. Inpatient Admissions and Concurrent Review

Initial Request for Inpatient Authorization

In situations where MedStar Family Choice receives requests for inpatient authorization accompanied by clinical review, MedStar Family Choice will communicate a decision within 72 hours (three calendar days) of receipt of your request.

Concurrent Review

MedStar Family Choice utilizes the following criteria to make concurrent review decisions:

- InterQual
- Medicare and Medicaid Guidelines
- COMAR
- MedStar Family Choice MCO benefit coverage

- Availability of services within the MedStar Family Choice network
- MedStar Family Choice UM Criteria Policy

MedStar Family Choice reviews clinical documentation for timeliness of care and appropriate level of care. Clinical denial determinations may be issued by our Medical Directors when a delay in care or delay in discharge planning creates an inpatient day that could have been avoided if service had been provided timely.

While MedStar Family Choice care managers are available to assist with discharge planning, it is the responsibility of the inpatient facility to provide timely and appropriate discharge planning. Inpatient days that do not meet medical necessity as outlined in above criteria are the responsibility of the inpatient facility.

In situations where MedStar Family Choice receives requests for additional urgent concurrent care that is accompanied by clinical review, MedStar Family Choice will communicate a decision within 72 hours (three calendar days) of receipt of your request.

In situations where MedStar Family Choice receives requests for additional urgent concurrent care that is NOT accompanied by clinical review it is MedStar Family Choice's process to make at least one attempt to request the outstanding clinical information. Clinical not received within 72 hours (three calendar days) of the authorization request will be subject to denial.

In the event that additional clinical is indicated, MedStar Family Choice may elect to grant an extension for up to 14 calendar days.

Services that are carved out to the State of Maryland Medicaid, which include but are not limited to behavioral health care, are subject to administrative denial since they are not the liability of MedStar Family Choice.

MedStar Family Choice follows MD Medicaid Fee for Service guidelines when conducting inpatient review in the event that a guardianship hearing is necessary to determine post-acute disposition. In the absence of medical necessity, MedStar Family Choice approves the first two days following the decision that guardianship is needed.

Emergency Care

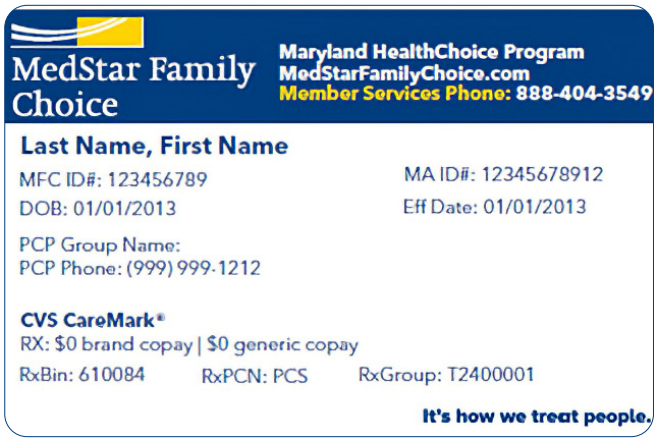
In accordance with the Emergency Medical Treatment & Labor Act (EMTALA), MedStar Family Choice will pay claims for all medical screening examinations when the request is made for examination or treatment for an emergency medical condition, including active labor. MedStar Family Choice does not consider a nurse exam or triage information as evidence of a medical screening exam.

In accordance with the Balanced Budget Act of 1997, MedStar Family Choice pays for emergency services using a prudent layperson standard. An "emergency medical condition" is defined as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual or, with respect to a pregnant member, or their unborn child in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

MedStar Family Choice requires and fully reviews emergency department clinical documentation for evidence of a medical screening exam, prudent layperson guidelines, as well as evaluation of assigned treatment levels based on HSCRC guidelines for reasonable relative value units.

Services that are carved out to the State of Maryland Medicaid, which include but are not limited to behavioral health care, are subject to administrative denial since they are not the liability of the MCO.



MedStar Family Choice does not specifically reward practitioners or other individuals for issuing denials of coverage of care. In addition, there are no financial incentives for UM decision makers that would encourage decisions that result in underutilization. Clinical Practice Guidelines for certain conditions can be found on the website. Providers may also call the MedStar Family Choice Care Management department to request a written copy. Providers may request the UM criteria utilized for a specific case by calling the MedStar Family Choice Care Management department at **800-905-1722** or **410-933-2200.**

E. Period of Preauthorization

Prior authorization numbers are valid for the date of service authorized or for a period not to exceed the date of service authorized. The member must be eligible for Medicaid and enrolled in MedStar Family Choice on each date of service.

Eligibility Verification

MedStar Family Choice Members are provided with an identification card indicating MedStar Family Choice as their chosen Managed Care Organization.

Providers must verify eligibility through EVS prior to rendering services to MedStar Family Choice members. The phone number for EVS is **866-710-1447.** The MDH also allows providers to verify eligibility on-line. The website is **EMDHealthChoice.org.**

Providers may contact MedStar Family Choice directly to verify a member's PCP. MedStar Family Choice members may change PCPs at any time. Members can call MedStar Family Choice Member Services Monday through Friday 8:30 a.m. – 5 p.m. at **888-404-3549** to change their PCP. PCPs may see MedStar Family Choice members even if the PCP name is not listed on the membership card.

As long as the member is eligible on the date of service and the PCP is participating with MedStar Family Choice, the PCP may see the MedStar Family Choice member. However, MedStar Family Choice does request that the PCP assist the member is changing PCPs so the correct PCP is reflected on the membership card. The office should contact Member Services **888-404-3549.** MedStar Family Choice's Outreach staff is available to providers Monday through Friday from 8:30 a.m. to 5 p.m. **800-905-1722** to answer any eligibility or PCP questions.

F. Prior Authorization and Coordination of Benefits

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

G. Medical Necessity Criteria

A “medically necessary” service or benefit must be:

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

H. Clinical Guidelines

Clinical practice guidelines for certain conditions can be found on the website. Providers may also call the MedStar Family Choice Care Management department to request a written copy. Providers may request the UM criteria utilized for a specific case by calling the MedStar Family Choice Care Management Department at **800-905-1722.**

I. Timeliness of Decisions and Notifications to Providers and Members

MedStar Family Choice makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the Maryland Department of Health. MedStar Family Choice adheres to the following decision/notification time standards:

- Standard authorizations - within two (2) business days of receipt of necessary clinical information, but not later than fourteen (14) calendar days of the date of the initial request;
- Expedited authorizations - no later than 72 hours after receipt of the request if it is determined the standard timeframe could jeopardize the member’s life, health, or ability to attain, maintain, or regain maximum function; and
- Covered outpatient drug authorizations - within 24 hours by telephone to either authorize the drug or request additional clinical information.

MedStar Family Choice will send notice to deny authorizations to providers and members:

- Standard authorizations - within 72 hours from the date of determination, not to exceed 14 calendar days from the receipt of request for authorization.
- Expedited authorizations - within 24 hours from the date of determination, not to exceed 72 hours from the receipt of request for authorization.
- Covered outpatient drug authorizations- within 24 hours of receipt of request.

J. Out-of-Network Providers

When approving or denying a service from an out-of-network provider, MedStar Family Choice will assign a prior authorization number, which refers to and documents the approval.

MedStar Family Choice sends written documentation of the approval or denial to the out-of- network

provider within the time frames appropriate to the type of request. Refer to Section I for list of self-referred services which are services we must allow members to access out-of- network. Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of- network provider. MedStar Family Choice makes such decisions on a case-by-case basis. Please note, submit a W9 along with your claim submission. If there was a single case agreement (SCA) executed with the out- of-network authorization request, please submit it with the claim.

K. Referral Process

A primary care physician (PCP) written referral to in-network specialists is not required for MedStar Family Choice Members.

While members can access in-network specialists without a written referral, referrals to an out of network specialist will require a written referral and prior authorization. It is essential that you utilize the MedStar Family Choice Quick Prior Authorization Guide, which details the services requiring prior authorization, to ensure timely approval for specialized care. For the latest version of the MedStar Family Choice Quick Prior Authorization Guide, please visit the Provider News section of our website at **MedStar Family Choice MD Provider News.** Claims for services provided by in-network specialists should be submitted as usual, with all necessary documentation included for efficient processing.

Referrals should be kept in the patient's chart and should not be sent to MedStar Family Choice. Referrals do not need to be submitted with a claim.

Routine Referrals

- Referrals are valid for six months from the date of issue. If a number of visits is not indicated on the referral, the referral is only valid for one visit.
- A specialist cannot refer to another specialist without authorization from the PCP. If a specialist determines that another specialist needs to be consulted, they must contact the patient's PCP for verbal or written approval. After receiving approval, the specialist should complete the Maryland Uniform Consultation Referral Form. The specialist must clearly indicate the PCP's approval on the referral and indicate on the form.
  The specialist should also copy the PCP on the notes from the consult. Exception: Specialists should directly refer patients for routine radiology, laboratory testing, rehabilitation, and DME services.

Laboratory Referrals

Members should be referred to one of MedStar Family Choice's in-network laboratories as identified in the below table:

In-Network MedStar Family Choice Laboratories	Maryland HealthChoice (Medicaid)
Accupath Diagnostic Laboratories (LabCorp subsidiary)	X
Caris Life Sciences (Genetic testing)	X
Dianon System (LabCorp subsidiary)	X

In-Network MedStar Family Choice Laboratories	Maryland HealthChoice (Medicaid)
Esoterix Genetic Laboratories (LabCorp subsidiary)	X
Exact Sciences Laboratories	X
Laboratory Corporation of America (LabCorp)	X
Lintholink Corporation (LabCorp subsidiary)	X
MedTox Laboratories (LabCorp subsidiary)	X
Monogram Biosciences (LabCorp subsidiary)	X
Myriad Genetic Laboratories	X
Myriad Women's Health	X
Sequenom Center for Molecular Medicine	X

Although laboratory service centers are available, it may be more convenient for members to have specimens drawn in a physician's office. MedStar Family Choice will reimburse for the collection of venous blood by venipuncture when collected in a physician's office, however, all specimens must be sent to the appropriate in-network laboratory for processing.

Laboratory specific payment guidelines including specific laboratory services that can be performed in the physician's office may be found on our website at **MedStarFamilyChoiceMD.com.** The list of specific laboratory services that can be performed in a physician's office may periodically change as CPT codes may be added to the list or modified to adhere to coding guidelines.

The most up to date information can be found on our website in the section labeled "For Providers" under the Provider Resources tab. For individuals that require genetic testing services please refer to our pre-authorization grid to ensure that no authorization needs to be given prior to the services being rendered to the member.

OB/GYN Referrals

There is no referral required for MedStar Family Choice OB/GYN visits that are annual, routine, or for gynecologic problems or obstetrical care.

Radiology Referrals

MedStar Family Choice has a network of free-standing radiology facilities throughout the service area. Please refer to the website for a network listing. If the provider office does not have access to the internet, providers may contact Provider Relations (**800-905-1722**) for a copy of the most current listing.

A Radiology Script or Uniform Consultation Form must be completed for all routine radiology services.

Specialists should refer Members directly for radiology services. Members should not be sent back to their PCP for a referral. Prior authorization is required for some radiology services.

A listing of procedures requiring prior authorization can be found at **MedStarFamilyChoiceMD.com**

(click on Maryland Providers, and select the Preauthorization and Utilization Management section).

Referrals are not required for screening mammograms at a participating free-standing radiology facility. A list of participating radiology locations can be found on our website at **MedStarFamilyChoiceMD.com.** Participating orthopedic providers may perform flat film x-rays in their office (POS 11) without an authorization.

Rehabilitation Referrals

MedStar Family Choice has an exclusive network for providing rehabilitation services (PT/OT/ ST). Please refer to the MedStar Family Choice website for a listing of participating sites (or contact Provider Relations for a written copy). PT/OT/ST and audiology services for members under the age of 21 are not covered by MedStar Family Choice. The State of Maryland reimburses for these services. Please make sure that when you refer a member under the age of 21 for any of these services that the provider participates in Maryland Medicaid.

Chiropractic services are not covered for adults.

Self-Referrals for Vision

Members may ask for information regarding routine vision or Maryland Healthy Smiles care. No referrals are required.

Vision	**866-998-5005** (AVESIS)
Dental **(For members under 21 years old ,pregnant members, and adult services)**	**888-696-9596** (MARYLAND HEALTHY SMILES)

Avesis will handle all routine vision services for our members. However, MedStar Family Choice will directly coordinate and manage the medical aspect of these services.

Urgent/Emergent Referrals

For patients requiring immediate services, please call MedStar Family Choice Care Management at **800-905-1722** or fax the MedStar Family Choice Prior Authorization Form to **410-933-2274.**

L. Overview of Member Complaint, Grievance and Appeal Processes

Our MCO member services line, operates toll-free at **888-404-3549** Monday through Friday between 8:30 a.m. and 5 p.m. Member services resolves or properly refers members' inquiries or complaints to the State or other agencies. MedStar Family Choice informs members and providers of the grievance system processes for complaints, grievances, appeals, and Maryland State Fair Hearings. This information is contained in the Member Handbook and is available on the MedStar Family Choice website at MedStarFamilyChoiceMD.com.

Members or their authorized representatives can file an appeal or a grievance with MedStar Family Choice orally or in writing. An authorized representative is someone who assists with the appeal on the member's behalf, including but not limited to a family member, friend, guardian, provider, or an attorney. Representatives must be designated in writing. Providers will not be penalized for advising or advocat-

ing on behalf of an enrollee. Members and their representatives may also request any of the following information from MedStar Family Choice free of charge, to help with their appeal by calling **800-905-1722:**

- Medical records;
- Any benefit provision, guideline, protocol, or criterion MedStar Family Choice used to make its decision;
- Oral interpretation and written translation assistance; and
- Assistance with filling out MedStar Family Choice's appeal forms. MedStar Family Choice will take no punitive action for:
- Members requesting appeals or grievances;
- Providers requesting expedited resolution of appeals or grievances;
- Providers supporting a member's appeal or grievance; or
- Members or providers making complaints against MedStar Family Choice or the Department.

MedStar Family Choice will also verify that no provider or facility takes punitive action against a member or provider for using the appeals and grievance system. Providers may not discriminate or initiate disenrollment of a member for filing a complaint, grievance, or appeal with MedStar Family Choice.

Our internal complaint materials are developed in a culturally sensitive manner, at a suitable reading comprehension level, and in the member's native language if the member is a member of a substantial minority. MedStar Family Choice delivers a copy of its complaint policy and procedures to each new member at the time of initial enrollment, and at any time upon a member's request.

MCO Member Grievance Procedures

A grievance is a complaint about a matter that cannot be appealed. Grievance subjects may include but are not limited to dissatisfaction with access to coverage, any internal process or policy, actions, or behaviors of our employees or vendors or provider office teams, care or treatment received from a provider, and drug utilization review programs applying drug utilization review standards.

Examples of reasons to file an administrative grievance include:

- The member's provider's office was dirty, understaffed, or difficult to access.
- The provider was rude or unprofessional.
- The member cannot find a conveniently located provider for their health care needs.
- The member is dissatisfied with the help they received from the provider's staff or MedStar Family Choice.

Examples of reasons to file a medical grievance include:

- The member is having issues with filling their prescriptions or contacting the provider.
- The member does not feel they is receiving the right care for their condition.
- MedStar Family Choice is taking too long to resolve the member's appeal or grievance about a medical issue.
- MedStar Family Choice denies the member's request to expedite their appeal about a medical issue.

Grievances may be filed at any time with MedStar Family Choice orally or in writing by the member or their authorized representative, including providers. MedStar Family Choice responds to grievances within the following timeframes:

- 30 calendar days of receipt for an administrative (standard) grievance;
- 5 calendar days of receipt for an urgent (medically related) grievance; and
- 24 hours of receipt for an emergent or an expedited grievance.

If we are unable to resolve an urgent or administrative grievance within the specified timeframe, we may extend the timeframe of the grievance by up to 14 calendar days if the member requests the extension or if we demonstrate to the satisfaction of the Maryland Department of Health (MDH), upon its request, that there is need for additional information and how the delay is in the member's interest. In these cases, we will attempt to reach you and the member by phone to provide information describing the reason for the delay and will follow with a letter within two (2) calendar days detailing the reasons for our decision to extend.

For expedited grievances, MedStar Family Choice will make reasonable efforts to provide oral notice of the grievance decision and will follow the oral notice with written notification. Members are advised in writing of the outcome of the investigation of all grievances within the specified processing timeframe. The Notice of Resolution includes the decision reached, the reasons for the decision, and the telephone number and address where the member can speak with someone regarding the decision. The notice also tells members how to ask the State to review our decision and to obtain information on filing a request for a State Fair Hearing, if applicable.

MCO Member Appeal Procedures

An appeal is a review by the MCO or the Department when a member is dissatisfied with a decision that impacts their care. Reasons a member may file an appeal include:

- MedStar Family Choice denies covering a service ordered or prescribed by the member's provider. The reasons a service might be denied include:
  - The treatment is not needed for the member's condition or would not help you in diagnosing the member's condition.
  - Another more effective service could be provided instead.
  - The service could be offered in a more appropriate setting, such as a provider's office instead of the hospital.
- MedStar Family Choice limits, reduces, suspends, or stops a service that a member is already receiving. For example:
  - The member has been getting physical therapy for a hip injury and they have reached the frequency of physical therapy visits allowed.
  - The member has been prescribed a medication, it runs out, and they do not receive any more refills for the medication.
- MedStar Family Choice denies all or part of payment for a service a member has received, and the denial was not related to the claim being "clean."
- MedStar Family Choice fails to provide services in a timely manner, as defined by the Department (for example, it takes too long to authorize a service a member or their provider requested).

- MedStar Family Choice denies a member's request to speed up (or expedite) the resolution about a medical issue.

The member will receive a Notice of Adverse Benefit Determination (also known as a denial letter) from us. The Notice of Adverse Benefit Determination informs the member of the following:

- MedStar Family Choice's decision and the reasons for the decision, including the policies or procedures which provide the basis for the decision.
- A clear explanation of further appeal rights and the timeframe for filing an appeal.
- The availability of assistance in filing an appeal.
- The procedures for members to exercise their rights to an appeal and request a State Fair Hearing if they remain dissatisfied with MedStar Family Choice's decision.
- That members may represent themselves or designate a legal counsel, a relative, a friend, a provider, or other spokesperson to represent them, in writing.
- The right to request an expedited resolution and the process for doing so.
- The right to request a continuation of benefits and the process for doing so.

If the member wants to file an appeal with MedStar Family Choice they have to file it within 60 days from the date of the denial letter. Our denial letters must include information about the HealthChoic Help Line. If the member has questions or needs assistance, direct them to call **800-284-4510.**

Providers may call the State's HealthChoice Provider Help Line at **800-766-8692.** If you would like to appeal a decision on a member's behalf, you must obtain the member's consent in writing and submit it to us. Written appeals must be sent to the following address:

MedStar Family Choice
P.O. Box 43790
Baltimore, MD 21236
Attn: Denial and Appeal Division

MedStar Family Choice will send the member a letter letting them know that MedStar Family Choice has received their appeal within five business days. If the member prefers to verbally request an appeal they should call **410-933-2200** or **800-905-1722** Monday through Friday between 8:30 a.m. and 5 p.m.

When the member files an appeal, or at any time during our review, the member and/or provider should provide us with any new information that will help us make our decision.

The member or representative may ask for up to 14 additional days to gather information to resolve the appeal. If the member or representative needs more time to gather information to help MedStar Family Choice make a decision, they may call MedStar Family Choice at **800-905-1722** and ask for an extension.

MedStar Family Choice may also request up to 14 additional days to resolve the appeal if we need to get additional information from other sources. If the MCO requests an extension, the MCO will send the member a letter and call the member and their provider.

When reviewing the member's appeal we will:

- Use doctors with appropriate clinical expertise in treating the member's condition or disease;

- Not use the same MCO staff to review the appeal who denied the original request for service; and
- Make a decision within 30 days, if the member's ability to attain, maintain, or regain maximum function is not at risk.

On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where a member's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the member's condition cannot be adequately managed without urgent care or services. MedStar Family Choice resolves expedited appeals effectively and efficiently as the member's health requires. Written confirmation or the member's written consent is not required to have the provider act on the member's behalf for an expedited appeal. If the appeal needs to be reviewed quickly due to the seriousness of the member's condition, and MedStar Family Choice agrees, the member will receive a decision about their appeal as expeditiously as the member health condition requires or no later than 72 hours from the request. If an appeal does not meet expedited criteria, it will automatically be transferred to a standard timeframe. MedStar Family Choice will make a reasonable effort to provide verbal notification and will send written notification within two calendar days.

Once we complete our review, we will send the member a letter letting them know our decision. MedStar Family Choice will send written notification for a standard appeal timeframe, including an explanation for the decision, within 30 calendar days from receipt of the appeal request.

For an expedited appeal timeframe, MedStar Family Choice will communicate the decision verbally at the time of the decision and in writing, including an explanation for the decision, within 24 hours of the decision.

If we decide that they should not receive the denied service, that letter will tell them how to ask for a State Fair Hearing.

Request to Continue Benefits During the Appeal

If the member's appeal is about ending, stopping, or reducing a service that was authorized, they may be able to continue to receive the service while we review their appeal. Providers may not request to continue benefits on the member's behalf. The member should contact us within 10 days of receiving the denial notice at **800-905-1722** if they would like to continue receiving services while their appeal is reviewed. The service or benefit will continue until either the member withdraws the appeal or the appeal or fair hearing decision is adverse to the member. If the member does not win their appeal, they may have to pay for the services that they received while the appeal was being reviewed.

Members or their designated representative may request to continue to receive benefits while the State Fair Hearing is pending. Benefits will continue if the request meets the criteria described above when the member receives the MCO's appeal determination notice and decides to file for a State Fair Hearing. If MedStar Family Choice or the Maryland Fair Hearing officer does not agree with the member's appeal, the denial is upheld, **and the member continues to receive services,** the member may be responsible for the cost of services received during the review. If either rendering party overturns MedStar Family Choice denial, we will authorize and cover the costs of the service within 72 hours of notification.

State Fair Hearing Rights

A HealthChoice member may exercise their State Fair Hearing rights but the member must first file an appeal with MedStar Family Choice. If MedStar Family Choice upholds the denial the member may

appeal to the Office of Administrative Hearings (OAH) by contacting the HealthChoice Help Line at **800-284-4510.** If the member decides to request a State Fair Hearing we will continue to work with the member and the provider to attempt to resolve the issue prior to the hearing date.

If a hearing is held and the Office of Administrative Hearings decides in the member's favor, MedStar Family Choice will authorize or provide the service no later than 72 hours of being notified of the decision. If the decision is adverse to the member, the member may be liable for services continued during our appeal and State Fair Hearing process. The final decision of the Office of Administrative Hearings is appealable to the Circuit Court, and is governed by the procedures specified in State Government Article, §10-201 et seq., Annotated Code of Maryland.

M. State HealthChoice HelpLines

State HealthChoice HelpLines

If a member has questions about the HealthChoice Program or the actions of MedStar Family Choice direct them to call the State's HealthChoice Help Line at **800-284-4510.** Providers can contact the HealthChoice Provider Line at **800-766-8692.**

V. Pharmacy Management

A. Pharmacy Benefit Management

MedStar Family Choice is responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program through the Pharmacy and Therapeutics (P&T) committee review that occurs quarterly. 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, new brand name drug rated as P (priority) by the FDA may be added to the formulary.

Coverage may be subject to preauthorization to ensure medical necessity for specific therapies. For formulary drugs requiring preauthorization, a decision will be provided within 24 hours of request if all necessary information is provided, a 14-day extension may be granted to obtain missing information to avoid unnecessary denials. When a prescriber believes that a non-formulary drug is medically indicated, we have procedures in place for non-formulary requests. The State expects a non-formulary drug to be approved if documentation is provided indicating that the formulary alternative is not medically appropriate. Requests for non-formulary drugs will not be automatically denied or delayed with repeated requests for additional information.

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

- Legend (prescription) drugs;
- Insulin;

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

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

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

MedStar Family Choice contracts with CVS Caremark® to provide the following services: pharmacy network contracting and network Point-of-Sale (POS) claim processing.

B. Mail Order Prescriptions

We cannot require a member to use mail-order, but we do offer mail-order pharmacy services for certain drugs.

MedStar Family Choice covers a 90-day supply of most chronic medications at retail pharmacies (some of which provide home delivery). To start the process, providers can send a prescription to the retail pharmacy for a 90-day supply. A full listing of medications available with a 90-day supply can be found at **Bit.ly/MFC90dayPharmacy.**

MedStar Family Choice members can also sign up for mail order pharmacy for chronic medications. A 90-day supply will be provided to members using mail order services. To start the process, prescribers may call CVS Caremark Mail Service Pharmacy™ at 800-996-5772 or they may submit a prescription to the CVS Caremark Mail Service Pharmacy™. A full listing of medications available with a 90-day supply from mail order can be found at **Bit.ly/MFC90dayPharmacy.**

C. Specialty Pharmacy Services

For specialty pharmacy services MedStar Family Choice contracts with CVS Caremark®. MedStar Family Choice is responsible for formulary development, drug utilization review, and prior authorization.

MedStar Family Choice's drug utilization review program is subject to review and approval by MDH and is coordinated with the drug utilization review program of the Behavioral Health Service delivery system.

D. Prescription and Drug Formulary

Check the current MedStar Family Choice formulary, **(Bit.ly/MFCProviderPharmacy),** before writing a prescription for either prescription or over-the-counter drugs MedStar Family Choice members must have their prescriptions filled at a network pharmacy.

Most Behavioral Health medications are paid by Medicaid not the MCO. The State's Medicaid formulary can be found at: **Client.FormularyNavigator.com/Search. aspx?siteCode=9381489506**

E. Prescription Copays

There are no copays for children under 21, pregnant members, Native Americans, individuals in a nursing facility or hospice, or for family planning.

F. Over-the-Counter Products

MedStar Family Choice covers many over the counter medications. The MedStar Family Choice Formulary lists the types of over-the-counter medications that are covered. In order for a MedStar Family Choice member to get an over-the-counter medication covered by MedStar Family Choice, the provider must call or electronically send a prescription to the pharmacy or handwrite a prescription for the member to take to the pharmacy. Refills are permitted. MedStar Family Choice will not pay for over-the-counter medications without a prescription. The only exception to this rule is for emergency contraception (e.g. Plan B and condoms). Neither of these over-the-counter products require a prescription to be covered by MedStar Family Choice. For specific questions, providers may contact our Care Management Department at **800-905-1722.**

G. Injectables and Non-Formulary Medications Requiring Prior-Authorization

Please refer to the MedStar Family Choice Formulary for a listing of medications that require prior authorization. Be aware that high dollar injectables, long-acting narcotics, and second-tier pharmacological agents require prior authorization. MedStar Family Choice pharmacy protocols and the MedStar Family Choice Formulary are available on the website. Written copies can be obtained upon request by calling the Provider Relations Department at **800-905-1722.**

We will expand our drug formulary to include new products approved by the Food and Drug Administration (COMAR 10.67.06.04D(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.

Coverage may be subject to preauthorization to ensure medical necessity for specific therapies.

When a prescriber believes that a non-formulary drug is medically indicated and submits appropriate supporting clinical documentation, MedStar Family will review for medical necessity.

H. Prior Authorization Process

MedStar Family Choice pays for a wide variety of medications, as outlined in our MedStar Family Choice Formulary. Some formulary medications require PA. A full list of these medications can be found in the Formulary and in the PA Table. Both documents are available on the website in the Provider Pharmacy section **(Bit.ly/MFCProviderPharmacy).**

- All non-formulary medications require PA.
- Brand medications (when a generic is available) require PA.
- Medications requiring Step Therapy when there is no evidence of a prescription for the first line medication require PA.
- Early refills (e.g., for lost medication, early refills, travel supplies) require PA. Please note that early refills for opioids or any other controlled dangerous substances are not permitted unless the patient has cancer related pain, is in hospice, receiving palliative care, or has sickle cell.

Providers may submit a pharmacy PA request to MedStar Family Choice. The request must include clinical documentation that supports the medical need for that specific medication. All PA requests are handled by a pharmacy technician or pre-certification nurse, then reviewed further by a Health Plan Pharmacist or Medical Director prior to a final decision. MedStar Family Choice does not guarantee coverage of medications that are outside the guidelines set forth in this manual. Physicians may call MedStar Family Choice at **410-933-2200,** or fax requests to **888-243-1790.**

Requests for PAs for medications are handled expeditiously such that decisions and notifications are made within 24 hours of the receipt of the request. If the service is denied, MedStar Family Choice will notify the prescriber and the member in writing of the denial.

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

Mental health medications and some antiseizure medications are covered by the Maryland Department of Health and are not covered by MedStar Family Choice. These requests are subject to administrative denials since they are not the liability of MedStar Family Choice.

I. Step Therapy and Quality Limits

For the most current information regarding medications requiring step therapy and quantity limits please go to the Pharmacy tab under the Providers section of **MedStarFamilyChoiceMD.com.**

J. Maryland Prescription Drug Monitoring Program

MedStar Family Choice complies with the Maryland Prescription Drug Monitoring Program. The Maryland Prescription Drug Monitoring Program (PDMP) is an important component of the Maryland Department of Health initiative to halt the abuse and diversion of prescription drugs. The Maryland Department of Health is a statewide database that collects prescription data on Controlled Dangerous

Substances (CDS) and Human Growth Hormone (HGH) dispensed in outpatient settings. The Maryland Department of Health does not collect data on any other drugs.

Pharmacies must submit data to the Maryland Department of Health at least once every 15 days.

This requirement applies to pharmacies that dispense CDS or HGH in outpatient

settings in Maryland, and by out-of-state pharmacies dispensing CDS or HGH into Maryland. Patient information in the Maryland Department of Health is intended to help prescribers and pharmacists provide better-informed patient care. The information will help supplement patient evaluations, confirm patients' drug histories, and document compliance with therapeutic regimens.

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

K. Corrective Managed Care Program

We restrict members to one pharmacy if they have abused pharmacy benefits. We must follow the State's criteria for Corrective Managed Care. The Corrective Managed Care (CMC)

Program is an ongoing effort by the Maryland Medicaid Pharmacy Program (MMPP) to monitor and promote appropriate use of controlled substances. Call **800-905-1722** if a member is having difficulty filling a prescription. The CMC program is particularly concerned with appropriate utilization of opioids and benzodiazepines. MedStar Family Choice will work with the State in these efforts and adhere to the State's opioid preauthorization criteria.

L. Maryland Opioid Prescribing Guidance and Policies

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

Policy

Prior authorization is required for long-acting opioids, fentanyl products, methadone for pain, and any opioid prescription that results in a patient exceeding 90 morphine milliequivalents **(MME) per day.[1] A standard 30-day quantity limit for all opioids is set at or below 90 MME per day.** The CDC advises "clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 MME/ day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/ day." In order to prescribe a long- acting opioid, fentanyl products, methadone for pain, and opioids above 90 MME daily, a prior authorization must be obtained every 6 months.

[1] Instructions on calculating MME is available at: **https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf**

[2] CDC guidance: **https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm** and CMS guidance: **https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf**

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

Naloxone should be prescribed to patients that meet certain risk factors. Both the CDC and Centers for Medicaid and Medicare Services have emphasized that clinicians should incorporate strategies to mitigate the risk of overdose when prescribing opioids.[2] We encourage providers to prescribe naloxone - an opioid antagonist used to reverse opioid overdose - if any of the following risk factors are present: history of substance use disorder; high dose or cumulative prescriptions that result in over 50 MME; prescriptions for both opioids and benzodiazepine or non-benzodiazepine sedative hypnotics; or other factors, such as drug using friends/family.

Guidance

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

Providers should screen for Substance Use Disorder. Before writing for an opiate or any controlled substance, providers should use a standardized tool(s) to screen for substance use. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an example of a screening tool.[3] Caution should be used in prescribing opioids for any patients who are identified as having any type of or history of substance use disorder. Providers should refer any patient who is identified as having a substance use disorder to a substance use treatment program.

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

Patients Identified with Substance Use Disorder Should be Referred to Substance Use Treatment. Maryland Medicaid administers specialty behavioral health services through a single Administrative Services Organization - Carelon Behavioral Health of Maryland. If you need assistance in locating a substance, use treatment provider, Carelon may be reached at **800-888-1965**. If you are considering a referral to behavioral health treatment for one of your patients, additional resources may be accessed at **https://maryland.carelonbh.com/.**

---

[3] A description of these substance use screening tools may be accessed at: **http://www.thenationalcouncil.org/resources/**

Providers should use the PMDP every time they write a prescription for CDS. Administered by MDH, the PDMP gives healthcare providers online access to their patients' complete CDS prescription profile.

Practitioners can access prescription information collected by the PDMP at no cost through the CRISP health information exchange, an electronic health information network connecting all acute care hospitals in Maryland and other healthcare facilities. Providers that register with CRISP get access to a powerful "virtual health record" that includes patient hospital admission, discharge and transfer records, laboratory and radiology reports, and clinical documents, as well as PDMP data.

For more information about the PDMP, visit the MDH website: **https://health.maryland.gov/PDMP/Pages/Home.aspx.** If you are not already a registered CRISP user, you can register for free at **CrispHealth.Force.com/Crisp2_Login.** PDMP usage is highly encouraged for all CDS prescribers and will become mandatory to check patients' CDS prescriptions if prescribing CDS at least every 90 days (by law).

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

VI. Claims Submission, Provider Appeals, Quality Initiatives, Provider Performance Data, and Pay for Performance

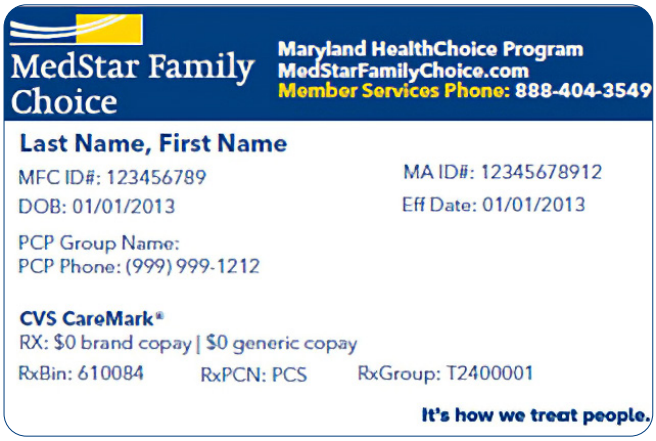
A. Facts to Know Before You Bill

You must verify through the Eligibility Verification System (EVS) that participants are assigned to MedStar Family Choice before rendering services.

Eligibility Verification

MedStar Family Choice members are provided with an identification card indicating MedStar Family Choice as their chosen Managed Care Organization.

Providers must verify eligibility through EVS prior to rendering services to MedStar Family Choice members. The phone number for EVS is **866-710-1447.** The MDH also allows providers to verify eligibility on-line.



The website is EMDHealthChoice.org. Providers may contact MedStar Family Choice directly to verify a member's PCP. MedStar Family Choice members may change PCPs at any time. Members can call MedStar Family Choice Member Services Monday through Friday 8:30 a.m. to 5 p.m. at **888-404-3549** to change their PCP. PCPs may see MedStar Family Choice members even if the PCP name is not listed on the membership

[3] A description of these substance use screening tools may be accessed at: **http://www.thenationalcouncil.org/resources/**

card. As long as the member is eligible on the date of service and the PCP is participating with MedStar Family Choice, the PCP may see the MedStar Family Choice member.

However, MedStar Family Choice does request that the PCP assist the member is changing PCPs so the correct PCP is reflected on the membership card. The office should contact Member Services **888-404-3549.** MedStar Family Choice's Customer Services staff is available to providers Monday through Friday from 8:30 a.m. to 5 p.m. **800-261-3371** to answer any eligibility or PCP questions.

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

B. Submitting Claims to MedStar Family Choice

All claims must be submitted to MedStar Family Choice within 180 calendar days from the date of service in accordance with Maryland law. MedStar Family Choice accepts the following submissions:

Electronic Submission

MedStar Family Choice encourages all providers to submit claims electronically. MedStar Family Choice participates with Change Healthcare. As long as you have the capability

to send EDI claims to Change Healthcare through direct submission or through another clearinghouse/vendor, you may submit claims electronically using **Payer ID# RP063.**

Paper Claims

MedStar Family Choice Claims Processing Center
P.O. Box 211702
Eagan, MN 55121

Clean claims will be processed within 30 days, in accordance with Maryland law. See the Billing Inquiries section for additional information on how to check claims status.

MedStar Family Choice follows the CMS National Correct Coding Initiative when adjudicating claims.

Credentialing and Claims for Nurse Practitioners and Physician Assistants

MedStar Family Choice requires credentialing for all providers who render services to our members including nurse practitioners and physician assistants. All providers rendering services must submit claims directly to MedStar Family Choice for processing and payment using their Type I NPI in the rendering field of the claim form.

ER Auto-Pay List

The MedStar Family Choice website contains the most up to date ER Auto-pay list. Visit **MedStarFamilyChoiceMD.com,** go to the Maryland Providers area and click on the Claims, Appeals, and Grievances section. Claims for emergency services with diagnosis codes on the auto-pay list will be paid without further documentation. MedStar Family Choice reserves the right to audit claims in accordance with Maryland regulations for consistency between clinical documentation and information presented on the bill (including the reported diagnosis). ER visits not included on the auto-pay list require medical documentation for payment. Providers may also obtain a copy of this auto-pay list by contacting the provider relations department.

Billing Inquiries

To obtain information on the status of your claims or to discuss the outcome of your claim, please call our Claims Department at **800-261-3371.** Our Claims department is available Monday through Friday, 8:30 a.m. – 5 p.m. You can also use the MedStar Family Choice claims look up on our website.

This allows providers to check the status of a claim. To check claims status online, providers should go to **MedStarFamilyChoiceMD.com,** select Maryland Providers and then select Claims, Appeals, and Grievances section. This takes you directly to the online claims look-up page where you can register and/or sign on and look up claims status. Additional details for how to register and log on can be found online at **https://www.medstarfamilychoicemd.com/maryland-providers/provider-resources.**

Provider Appeal of MedStar Family Choice Claim Denial Claims Payment Dispute MedStar Family Choice has a form for your convenience called the Claims Payment Dispute Form. This form contains all the information that is required to process your request. Please complete the form in its entirety and mail the form to the address listed on the Claims Payment Dispute form. Providers must use the Claims Payment Dispute form for all payment disputes, or your request will not be processed.

Copies of this form are available on the MedStar Family Choice website, **MedStarFamilyChoiceMD.com** in the Maryland Providers area under the Claims, Appeals, and Grievances section.

Formal Appeal Process

MedStar Family Choice will accept appeal requests in writing within applicable time frames using the Medicaid Appeal Form from the website. Appeal requests must include a clearly expressed request for the appeal or re-evaluation. The request must include the reason and supporting documentation as to why the Adverse Action (denial) was believed to have been issued incorrectly.

MedStar Family Choice will send a letter to confirm the appeal within 5 business days of receipt of the appeal request. MedStar Family Choice will make a decision within 30 days from the date of the appeal and send a letter with the decision.

Providers acting on their own behalf are defined as those who dispute Adverse Actions when the service has already been provided to the member and there is no member financial liability. First level appeals must be submitted in writing within 90 business days from the date of the Remittance Advice (RA) / denial notice. The appeal must outline reasons for the appeal with all necessary documentation including a copy of the claim and the RA, when applicable. Appeal requests for medical necessity decisions must include supporting clinical/medical documentation.

A provider appeal must include a clearly expressed reason for re-evaluation, with an explanation as to why the denial was believed to have been issued incorrectly. An acknowledgement of receipt of the appeal (first and second level) will occur within five business days of receipt.

Second level appeals must be submitted within 30 calendar days of the first level appeal notification letter. The second level appeal is the final level of appeal. MedStar Family Choice will respond within 30 calendar days of receipt of the second level appeal. Please use the Medicaid Appeal Form and mail the written request with all supporting documentation, such as clinical/medical documentation.

Overpayments – Notices, Refunds & Recoupments

If a provider receives an overpayment for a Maryland HealthChoice plan claim, the provider shall report and refund such overpayment within 60 calendar days of the date on which the overpayment was identified by Provider, in a manner consistent with the requirements of applicable law, including without limitation 42 U.S.C. 1320a-7k(d) and applicable regulations. Please submit the refund using the Overpayment/ Refund Form located on **MedStarFamilyChoiceMD.com** **along with a copy of the Remittance Advice and any other supporting documentation** identifying the overpayment to the address below:

MedStar Family Choice
10980 Grantchester Way, 5th Floor
Columbia, MD 21044

If an overpayment to a provider has been identified by MedStar Family Choice, MedStar Family Choice may send a written notice to the provider demanding repayment of such overpayment. Provider shall refund to MedStar Family Choice the amount of such overpayment in a manner as set forth in the notice letter, or may challenge such overpayment determination under the applicable appeals process set forth in the notice letter. If the provider fails to timely refund the overpayment or fails to fully prevail upon appeal, MedStar Family Choice may recoup such overpayments from provider in a manner consistent with applicable federal and state laws including, without limitation, through the deduction or off-setting of overpayments from future payments owed to the provider. The related claim information will be shown on the remittance advice as a negative amount. Providers will be notified of overpayment and/or retraction of funds.

Providers with questions concerning overpayments should contact the MedStar Family Choice Claims department at **800-261-3371.**

Denial of Claims

Denial of claims is considered a contractual issue between the MCO and the provider. Providers must contact the MCO directly. The Maryland Insurance Administration refers MCO billing disputes to MDH. MDH may assist providers in contacting the appropriate representative at MedStar Family Choice but MDH cannot compel MedStar Family Choice to pay claims that MedStar Family Choice administratively denied.

C. State's Independent Review Organization (IRO)

The Department contracts with an IRO for the purpose of offering providers another level of appeal for providers who wish to appeal medical necessity denials only. Providers must first exhaust all levels of the MCO appeal process. By using the IRO, you agree to give up all appeal rights (e.g., administrative hearings, court cases). The IRO only charges after making the case determination. If the decision upholds the MCO's denial, you must pay the fee. If the IRO reverses the MCO's denial, the MCO must pay the fee. The web portal will walk you through submitting payments.

The review fee is $425. More detailed information on the IRO process can be found at **https://health.maryland.gov/mmcp/Documents/Quick%20Reference%20Guide%20for%20Providers.pdf.**

The IRO does not accept cases for review which involve disputes between the Behavioral Health ASO and MedStar Family Choice.

Quarterly Complaint Reporting

We are responsible for gathering and reporting to the State information about member'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 Enrollee Services and Hotline Information

MedStar Family Choice maintains a member services unit **(888-404-3549)** which is available Monday through Friday 8:30 a.m. – 5 p.m. Calls or faxes received after hours will be addressed the next business day. This unit handles and resolves or properly refers members' inquiries or complaints to other agencies. Additionally, MFC provides members with information about how to access our member services unit to obtain information and assistance.

D. Quality Initiatives

Quality Improvement Plan

The quality improvement 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. Daily and through a systematic process of annual audits of MCO operations and health care delivery, the Department identifies both positive and negative trends in service delivery.

Quality monitoring, evaluation, and education through member and provider feedback are integral parts of the managed care process and help to ensure that cost containment activities do not adversely affect the quality of care provided to members.

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

assurance monitoring methodologies; and developing, implementing, and evaluating quality indicators, outcomes measures and data reporting activities.

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

- Health Service Needs screening conducted by the enrollment broker at the time the participant selects an MCO to assure that the MCO is alerted to immediate health needs, e.g., prenatal care service needs
- A complaint process administered by Department staff
- A complaint process administered by MedStar Family Choice
- 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®[1]). 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 MDH.
- The annual collection and evaluation of a set of performance measures identified by the Department
- An annual member satisfaction survey using the Consumer Assessment of Health Plans Survey (CAHPS®[2])
- Monitoring of preventive health, access and quality of care outcome measures based on encounter data
- Development and implementation of 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

In order to report many of these measures to MDH, MedStar Family Choice must perform chart audits throughout the year to collect clinical information on our members. MedStar Family Choice truly appreciates the provider offices' cooperation when medical records are requested.

The goal of MedStar Family Choice's Quality Improvement Plan's is to provide the highest quality of care and deliver the best outcomes for members. The Quality Improvement Department consists of a team of registered nurses, data analysts, specialists, and a population health coordinator who work to integrate various improvement strategies across departments and coordinate the collection of data to identify, analyze, and trend opportunities for improvement. They educate our providers on MedStar Family Choice's performance improvement projects and quality improvement activities.

They produce and deliver performance-based scorecards and member gaps in care to network providers.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

E. Provider Performance Data

Providers agree that MedStar Family Choice may utilize a provider's performance data in numerous ways including but not limited to:

- Recredentialing
- Pay for performance
- Quality improvement activities
- Public reporting to consumers
- Preferred status designation in the network (tiering) for narrow networks
- Reduced member cost sharing and
- Other quality activities.

F. Pay for Performance

MedStar Family Choice will reach out to your office in the event that you would be eligible for any program that may be developed.

VII. Provider Services and Responsibilities

A. Overview of MedStar Family Choice Provider Services

Provider Relations is available to assist practitioners with initiating the credentialing/ contracting process, educate on MedStar Family Choice Policies and Procedures, assist with provider concerns and inquiries.

Provider Relations also conducts site evaluations for new provider locations and assist with scheduling in-office interpreter services. Request for in-office interpretation services should be submitted no less than five business days prior to a scheduled/non-urgent appointment.

Our Provider Relations department is available Monday through Friday 8:30 a.m. – 5 p.m. If you have any questions about MedStar Family Choice, or the information contained in this manual, please do not hesitate to contact Provider Relations at **800-905-1722 option 5.**

The MedStar Family Choice website is updated regularly. Users can log on to **MedStarFamilyChoice.com** and view:

- Appeal Process
- Availability of UM Criteria
- Case Management And Disease Management Services
- Claims Information (including a link to the Online Claims Status Check)
- Clinical Practice Guidelines
- Contact Information for MedStar Family Choice
- Credentialing Process

- False Claims Act/Fraud And Abuse
- Find-A-Provider (searchable provider directory)
- Formulary
- Hours of Operation and After-Hours Instructions
- Interpreter Services
- Medical Record Documentation Guidelines
- Member Rights and Responsibilities
- Notice of Privacy Practices
- Outreach Program
- Pharmacy Protocols and Procedures
- Pre-Authorization Requirements
- Provider Alerts
- Provider Manual
- Provider Newsletters
- Quality Improvement Programs
- Quick Reference Guide
- Schedule of Health Education Classes
- Transportation Guidelines
- Utilization Management Decision Making

If your office does not have access to the Internet, all of these materials are available in print by contacting our Provider Relations department, Monday through Friday, 8:30 a.m. to 5 p.m., at **800-905-1722, option 5.**

B. Provider Services and Provider Web Portal

To obtain information on member eligibility, benefits, PCP assignment, check the status of your claims, or to discuss the outcome of your claim, please call our Provider Services department at **800-261-3371.** Provider Services is available Monday through Friday, 8:30 a.m. to 5 p.m.

Online Claims Look Up/Registration

The MedStar Family Choice claims look up website allows providers to check claims status online 24/7. To check claims status, providers must go to **MedStarFamilyChoiceMD.com,** select Maryland Providers and then select the Claims, Appeals, and Grievances section. The Access Claim Portal website allows providers to sign in as a returning user or register as a new user.

In addition to the initial master account holder registration, providers may also set up subaccounts for additional users in their office. Subaccounts will allow multiple users to share the same web portal access without sharing the same username and password. The employee who is registered as the master account will be responsible for activating and deactivating employee logins. All identifying information needed for registration must exactly match the information in our database. Therefore, we recommend

that offices have a copy of an EOP to refer to for accurate data input of Provider Name, ID, and address information.

Directions for registering as a new user can be found online at:

https://www.medstarfamilychoicemd.com/maryland-providers/provider-resources

C. Provider Inquiries

To obtain information on member eligibility, benefits, PCP assignment, check the status of your claims, or to discuss the outcome of your claim, please call our Provider Services Department at **800-261-3371**. Our Provider Services Department is available Monday through Friday 8:30 a.m. to 5 p.m.

If you need assistance from Care Management for requests related to prior authorization, from Outreach for non-emergency transportation, assistance with preventative care or member compliance issues, or Provider Relations for contracting, credentialing, training, problem solving, setting up in office interpreter services or cultural competency concerns, please call **800-905-1722** and select the appropriate option.

D. Recredentialing

MedStar Family Choice, in accordance with state and federal regulatory authorities, credentialing authorities, and other accrediting body (NCQA, CMS, etc.), requires recredentialing of providers every three years. If providers do not have a current and up to date CAQH record, or they do not participate with CAQH, the providers will be contacted several months prior to the actual reappointment date to begin the recredentialing process. Providers must also have an active Maryland Medicaid Fee For Service provider number (rendering and Pay-To) at the time of recredentialing.

E. Overview of Provider Responsibilities / Provider Information Changes

During the time a provider is contracted with MedStar Family Choice, the provider may have changes in office locations, Tax-ID number, phone number, and other demographic information. To comply with CMS regulations regarding the accuracy of our provider directory

information, MedStar Family Choice has developed the MedStar Family Choice Provider Web Portal. The MedStar Family Choice Provider Web Portal serves as a quality control mechanism allowing providers to view their information in our system. Your provider information is communicated to the MedStar Family Choice members and provider community via our Find a Provider website. Other systems within MedStar Family Choice also use this information to process authorizations, claims and issue reimbursement checks.

Provider Web Portal Services include:

- Provider and Group Changes
- Quarterly Data Validations
- Provider Web Portal User Guide

Visit the MedStar Family Choice Provider Web Portal at **https://providerportal.medstarfamilychoice.com/** to register.

Providers without internet access, must submit changes to the MedStar Family Choice Provider Data Management department by email to or by fax to **855-600-3077.**

Provider Relations performs site audits on all providers who open a new office location before any demographic changes are made to the provider's individual and group record in the credentialing database. Members should not be seen in the new location until the site visit has been performed.

Complete change requests are processed within 14 days of receipt and successful completion of the site evaluation for the new location. If Provider Relations must obtain other documents or clarification regarding the change, this will cause a delay in the processing time. The MedStar Provider Relations department will validate the provider demographic information on file once a quarter. All providers are required to participate in the quarterly validation process.

Provider Termination

If a provider decides that they no longer wish to be a part of the MedStar Family Choice network, the provider must submit a termination letter and allow 90 days from the time your letter is received by the Provider Relations department.

MedStar Family Choice will notify members of any Primary Care Provider terminations prior to the provider's termination date. The members will be given the option of choosing a new PCP or being assigned to one. For members assigned to PCP groups, the members are given notice that the provider within the group has left the practice. Members will remain assigned to the group unless the member calls Member Services to change PCPs. In some cases, members who are in active treatment may be able to continue seeing the PCP for up to 90 days after the termination. The provider should contact Care Management to discuss continuity of care issues.

For specialists who are terminating, MedStar Family Choice will notify members in active care with the provider of the provider's termination with the health plan. The member will be advised to select a new specialist provider, and to contact Member Services if they require assistance. In some cases, for those members in active treatment, MedStar Family Choice and the terminating provider may agree to extend the member's care under the terminating provider for a period up to 90 days. The provider should contact Care Management to discuss continuity of care issues.

F. Primary Care Providers (PCP)

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

The PCP is required to:

- Address the member's general health needs
- Treat illnesses
- Coordinate the member's health care
- Promote disease prevention and maintenance of health

- Maintain the member's health records and
- Refer for specialty care when necessary
- Offer hours of operation to MedStar Family Choice members that are no less in number or scope than the hours of operation offered to commercial or other Medicaid patients.

The following appointment guidelines must be followed:

- Provide well-child assessments, routine and preventative primary care appointments: 30 days from request
- Provide newborn visits: 3 to 5 days after birth
- Urgent care requests: 48 hours from request
- Provide initial assessment of pregnant and postpartum members and those requesting family planning services: 10 days from request
- Provide acute evaluation and treatment of medical emergencies in your office or the emergency room
- Provide all routine injections and immunizations required by AAP, CDC, AATD, ASM, EPSDT including, but not limited to:
  - Vaccines for MedStar Family Choice members age 18 and younger should be obtained through the Vaccines for Children Program (VFC). Vaccinations covered by the VFC program will not be reimbursed by MedStar Family Choice. Please contact the VFC program at **410-767-6030** for additional information.
- Provide all other coordination of care, counseling, patient education, discussion with family members, paperwork, risk factor reduction interventions, and health risk assessments'
- Provide or arrange coverage via answering service, 24 hours a day, 7 days a week with no charge to patients
- When ordering medications or writing prescriptions, physicians need to reference the MedStar Family Choice formulary and prior-authorization list as appropriate

If a member's PCP is not a member's health specialist, MedStar Family Choice will allow her to see a member's health specialist within the MCO network without a referral, for covered services necessary to provide member's routine and preventive health care services. Prior authorization is required for certain treatment services.

PCP Contract Terminations

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

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

G. Specialty Providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. MDH requires MedStar Family Choice to maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits. If a PCP cannot locate an appropriate specialty provider, call **800-905-1722** for assistance.

The responsibilities of participating MedStar Family Choice Specialty Care Physicians are as follows:

- Provide Specialty services indicated by referral from the primary care provider.
- Work closely with the primary care provider to ensure continuity of medical care and recommend appropriate treatment programs as well as provide written consultation reports to the referring physician.
- Obtain pre-authorization for procedures requiring authorization from MedStar Family Choice Care Management department.
- Collect laboratory specimens in office or send members to a participating lab as needed. Providers must use a participating lab requisition form when ordering laboratory testing to guarantee proper routing of results and ensure that the patient is not billed for the service.
- Refer members for radiology by completing the Maryland Uniform Consultation Referral Form or a script to a contracted radiology site.
- Refer members to contracted vendors for Durable Medical Equipment (DME) and follow MedStar Family Choice authorization requirements.
- Refer members for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) by completing the Maryland Uniform Referral Form to the contracted rehabilitation sites.
- Contact the primary care provider if additional services outside the specialist's practice are required.
- Comply with MedStar Family Choice Case Management for concurrent review and discharge planning.
- MedStar Family Choice providers must offer hours of operation to MedStar Family Choice members that are no less in number or scope than the hours of operation offered to commercial or other Medicaid patients. The following appointment guidelines must be followed:
  - Routine specialist follow-up appointments: 30 days from request.
  - Urgent care requests: 48 hours from request.

Obstetrical and Gynecological Provider

A female member age 12 and over may opt to have all her routine gynecological care, including her annual gynecological examination and Pap smear, as well as any other routine gynecological care performed by either her PCP or a participating gynecologist.

If the member elects to have her annual examination or other gynecologic-related services performed by a participating gynecologist, the protocol below must be followed:

- The member must use a participating OB/GYN from the MedStar Family Choice Specialist Network.

- No referral is necessary for visits which are annual, routine or for other gynecologic- related problems.
- Following each visit for gynecological care, the OB/GYN must ensure clinical communication with the PCP concerning any diagnosis or treatment rendered.
- The OB/GYN must confer with the member's PCP prior to performing any diagnostic procedure that is not in the scope of routine office care.
- The OB/GYN shall contact the member's PCP for all referrals for other specialty care (e.g., oncologist, neurologists, therapists, etc.).

Obstetrical Care For Normal OB Patients

Minimum Diagnostic Procedures: The initial diagnostic procedures may be done at the primary care provider's office and the results forwarded to the OB physician. Note: A participating OB/ GYN does not need a global OB referral to perform these services.

Upon confirmation of pregnancy, the Maryland Prenatal Risk Assessment must be completed and forwarded as required by the State. MedStar Family Choice requests that providers also send a copy of this form to the MedStar Family Choice Care Management Department. The fax number is **410-933-2274** or **888-243-1790.** MedStar Family Choice will review the assessment and contact the member to offer appropriate services and referrals. Pregnant members who are less than 28 weeks pregnant will be offered membership into the Momma and Me Program. This program provides many incentives for the member to be compliant with pre-natal, post-partum, health education, and well-baby visits.

Note: All laboratory services must be sent to a participating lab. Please be sure to use a participating lab requisition form when sending a patient for lab services.

MedStar Family Choice providers must offer hours of operation to MedStar Family Choice members that are no less in number or scope than the hours of operation offered to commercial or other Medicaid patients. Initial assessment of pregnant and postpartum members and those requesting family planning services: 10 days from request.

Frequency and Criteria of Office Visits should closely model the following schedule:

- Monthly for the first trimester.
- Every four weeks through 32 weeks.
- Every two to three weeks until 36 weeks.
- Every week after 36 weeks Initial visit.
- Evidence of prenatal education to include: Diet, smoking, and alcohol and drug usage.
- Obstetrical history.
- Family/social history.
- Physical evaluation.
- Genetic/birth defect screening with appropriate referrals and authorizations.

Each subsequent visit:

- Evidence within the record of standard physical findings with appropriate diagnosis, treatment, and follow-up for abnormalities including: fundal height and fetal heart rate.

- Monitoring BP.
- Identify high-risk patients and refer as necessary after approval from the PCP, i.e., nutritional counseling for gestational diabetes, etc..
- Monitoring weight.

Counseling/Education for:

- HIV screening discussed, offered, and/or completed.
- Substance abuse
- Postpartum: Postpartum examination should be scheduled between four and six weeks after delivery. This should include a clearly documented family planning discussion (including patient's plans for birth control) and discharge back to PCP.

High Risk OB Patients

High risk care includes all the services outlined previously in "Obstetrical Care For Normal OB Patients." If any further diagnostic testing is required, it may need to be approved through Care Management at **800-905-1722,** so that the care is coordinated and case managed, and/or proper referrals to ancillary services can be made. Please refer to the MedStar Family Choice authorization requirements for information regarding OB services requiring prior authorization.

Specialist Contract Terminations

For specialists that are terminating, MedStar Family Choice will notify members in active care with the provider of the provider's termination with the health plan. The member will be advised to select a new specialist provider, and to contact Member Services if they require assistance. In some cases, for those members in active treatment, MedStar Family Choice and the terminating provider may agree to extend the member's care under the terminating provider for a period up to 90 days. The provider should contact Care Management to discuss continuity of care issues.

H. Out-of-Network Providers and Single Case Agreements

Out-of-network providers need to secure a prior authorization for care that is not rendered in an emergency situation by calling **800-905-1722.** MedStar Family Choice should be notified within 24-72 hours of an emergency. Out-of-network providers will only be reimbursed for covered and prior authorized services to our members based on the Maryland Medicaid Fee Schedule unless the parties have agreed to a different level of reimbursement in advance of services being rendered and a Single Case Agreement has been executed. Please note provider must have a valid Maryland Medicaid provider number from the Maryland Department of Health to be eligible for reimbursement.

I. Second Opinions

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

J. Provider Requested Member Transfer

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask a member to leave their practice. Such requests cannot be based solely on the member filing a grievance, an appeal, a request for a Fair Hearing, or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

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

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

Email: **mfc-providerrelations2@medstar.net**
Fax: **855-600-3077**

MedStar Family Choice
10980 Grantchester Way, 5th Floor
Columbia, MD 21044
Attn: Provider Relations

- The provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care.
- Upon request, the provider will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

K. Medical Records Requirements

Confidentiality of Medical Records

MedStar Family Choice participating practitioners will maintain confidential medical records. At a minimum:

1. Records will be stored securely.
2. Only authorized personnel will have access to records. Electronic records will be password protected.
3. Practitioner workforce members will receive training in confidentiality, privacy, and security requirements pertaining to member protected health information within 90 days of being hired and annually thereafter.
4. Prior to obtaining access to member information, practitioner workforce members will sign a confidentiality statement to confirm their adherence to confidentiality, privacy, and security requirements.
5. Notification of privacy practices must be given to the patient per HIPAA requirements.

Medical Record Documentation Standard

1. All network Practitioners will maintain medical records that include at a minimum the following:.
    a. The date of service.

b. History and physicals.

c. Allergies and adverse reactions.

d. Problem list.

e. Medications.

f. Documentation of clinical findings and evaluation for each visit.

g. Preventive services/risk screening and an.

h. Immunization summary sheet.

i. Chief complaint or purpose for the visit.

j. Objective findings.

k. Diagnosis or medical impression.

l. Studies ordered (lab, x-ray, etc.)

m. Therapies administered or ordered.

n. Education provided

o. Disposition, recommendations, instructions to the member and evidence of whether there was follow-up; and

p. Outcome of services.

2. Primary Care Practitioners records will at a minimum reflect:

   a. All services provided directly by the practitioner.

   b. All ancillary services and diagnostic tests ordered by the practitioner.

   c. All diagnostic and therapeutic services for which a member of MedStar Family Choice was referred by the practitioner including home health nursing reports, specialty physician reports, consultations and letters, hospital discharge summaries, physical therapy reports, and others.

   d. Outreach efforts, letters to the local health department, etc. if applicable.

Organized Medical Record Keeping System and Standards for the Availability of Medical Records

1. MedStar Family Choice expects that all network practitioners maintain medical records that are organized and that are stored in a manner that allows easy retrieval.
2. Practitioners must implement mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to unauthorized individuals. Medical records must be stored in a secure manner that allows access by authorized personnel only. File cabinets and other medical record storage areas should have locks. Electronic records must have secure access and passwords.
3. In Maryland, medical records must be made available in no more than 21 working days from date of request. Urgent requests will be fulfilled promptly in accordance with the clinical situation and applicable requirements. Providers are responsible for adhering to verification requirements and to the timelines for responses to medical record requests which apply in their respective jurisdiction by law and/or regulation.
4. Medical records must be retained for a duration in accordance with all applicable laws, regulations, and contract requirements.

5. Providers must adhere to laws and regulations in their jurisdiction which govern records and releases, including requirements pertinent to records on mental health services, substance use, and other sensitive classes of information.

L. Confidentiality and Accuracy of Member Records

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

Providers must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations **(HHS.gov/OCR/Privacy/).**

M. Reporting Communicable Disease

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

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

N. Advance Directives

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

- Providing written information to adult members regarding each individual's rights under Maryland law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the member's medical record, whether or not the adult member has been provided the information and whether an advance directive has been executed.

- Not discriminating against a member because of their decision to execute or not execute, an advance directive and not making it a condition for the provision of care.
- Educating staff on issues related to advance directives, as well as communicating the member's wishes to attending staff at hospitals or other facilities.
- Educate patients on Advance Directives (durable power of attorney and living wills).
- Encourage patients to utilize electronic advance care planning documents.
- MCOs are required to make the Advance Directives Information Sheet available during enrollment and in member publications, on their website, and at the member's request.

Advance directive forms and frequently asked questions can be found at: **MarylandAttorneyGeneral.gov/Pages/HealthPolicy/AdvanceDirectives.aspx**

Communications toolkit for the Advanced Directive Information Sheet can be found at: **https://mhcc.maryland.gov/mhcc/Pages/hit/hit_advancedirectives/hit_advancedirectives_communications_toolkit.aspx.**

O. Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy and security provisions. The Health Insurance Portability and Accountability Act (HIPAA) impacts what is referred to as covered entities; specifically, providers, health plans, and health care clearinghouses that transmit healthcare information electronically. The Health Insurance Portability and Accountability Act (HIPAA) have established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit **HHS.gov/OCR/HIPAA.** In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

P. Cultural Competency

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

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

Q. Health Literacy - Limited English Proficiency (LEP) or Reading Skills

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

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

MedStar Family Choice does provide interpreters for members that require such services. MedStar Family Choice utilizes a language line and can provide for in-office translation services when necessary. Providers may contact the Care Management department at **800- 905-1722** to schedule telephonic translation services. Providers may contact Provider Relations at **800-905-1722** to coordinate in-office translation services. Requests for in-office interpreters should be requested no less than five business days before a scheduled/non-emergent appointment.

R. Access for Individuals with Disabilities

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

VIII. Quality Assurance and Monitoring Plan and Reporting Fraud, Waste, Abuse and Payment Integrity

Quality Assurance Monitoring Plan

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

The Department's quality assurance monitoring plan is a multifaceted strategy for assuring that the

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

- Health Service Needs Information form completed by the participant at the time they select an MCO to assure that the MCO is alerted to immediate health needs, e.g., prenatal care service needs ;
- A complaint process administered by MDH staff ;
- A complaint process administered by MedStar Family Choice ;
- A systems performance review of each MCO's quality improvement processes and clinical care performed by an External Quality Review Organization (EQRO) selected by the Department. The audit assesses the structure, process, and outcome of each MCO's internal quality assurance program;
- Annual collection, validation and evaluation of the Healthcare Effectiveness Data and Information Set (HEDIS), a set of standardized performance measures designed by the National Committee for Quality Assurance and audited by an independent entity;
- Other performance measures developed and audited by MDH and validated by the EQRO ;
- An annual member satisfaction survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS), developed by NCQA for the Agency for Healthcare Research and Quality;
- Monitoring of preventive health, access, and quality of care outcome measures based on encounter data ;
- Development and implementation of an outreach plan ;
- A review of services to children to determine compliance with federally required EPSDT standards of care ;
- Production of a Consumer Report Card ; and
- An annual technical report that summarizes all quality activities.

To report these measures to MDH, MedStar Family Choice must perform chart audits throughout the year to collect clinical information on our Members. MedStar Family Choice truly appreciates the provider offices' cooperation when medical records are requested. In addition to information reported to MDH, MedStar Family Choice collects additional quality information. Providers may need to provide records for standard medical record audits that ensure appropriate record documentation. Our Quality Improvement staff may also request records or written responses if quality issues are raised in association with a member complaint, chart review, or referral from another source.

Fraud, Waste, and Abuse Activities

MedStar Family Choice and MedStar Health have comprehensive compliance programs in place to monitor and detect fraud and abuse. Fraud and abuse could be committed by a provider, member, or even an employee of the MCO. As a MedStar Family Choice provider, it is a provider's responsibility to report fraud and abuse.

Medicaid defines fraud as an intentional deception made by a person or company with the intent to gain some unauthorized benefit from the deception. Medicaid defines abuse as practices that do not follow

sound financial, business, or medical practice and result in unnecessary costs or do not meet a standard of care. Some common examples of fraud and abuse are:

- Billing for a service that was never performed
- Billing for a service that was rendered by another practitioner
- Unbundling of procedures
- Upcoding
- Performing unnecessary procedures
- Altering or forging a prescription
- Allowing others to use a member's ID card for care
- Pass-through billing

Most billing errors are oversights and not indicators of fraudulent activity. However, fraud and abuse does occur and the Maryland Department of Health (MDH) has tasked MedStar Family Choice with monitoring, identifying, and deterring these types of activities. As a result, MedStar Family Choice regularly monitors and audits claims submissions and encounter data. In addition, MedStar Family Choice performs routine and random chart audits as a part of the Compliance Program. Providers are required to comply with these audits. MDH expects MedStar Family Choice to report fraud and abuse. MDH Office of the Inspector General – Health (OIG-H) or the MD Office of the Attorney General Medicaid Fraud and Vulnerable Victims Unit (MFVVU) may perform its own investigation. Penalties such as fines, loss of licensure, or imprisonment can occur for providers found guilty of fraudulent activity.

If overpayments related to fraudulent or abusive billing has been identified, MedStar Family Choice may retract payments made to providers. In addition, under certain circumstances (Maryland Medicaid MCO Transmittal No. 82) MedStar Family Choice may be required to notify the MDH Office of the Inspector General – Health and the MD Office of the Attorney General Medicaid Fraud and Vulnerable Victims Unit of the retraction.

Providers will be notified of the retraction. The notification will include the following:

1. The reason for retractions of payments
2. The amount to be retracted
3. A list of claims that will be retracted
4. Notification of the providers right to appeal

Providers will have 30 business days to appeal. The appeal must be submitted to in writing and to the following address:

MedStar Family Choice
10980 Grantchester Way 5th Floor
Columbia, MD 21044A
Attn: Director of Medicaid Contract Oversight

If additional documentation is available to support the reversal of the denied services, this should be submitted at this time. MedStar Family Choice will send a written acknowledgement to the provider of receipt of the appeal within 5 business days. MedStar Family Choice will notify the provider of the determination of the appeal, in writing, within 30 calendar days of the receipt of appeal.

Payment Integrity

Claims must be billed and paid in accordance with laws, regulatory requirements, CMS billing guidelines, provider contracts, and MedStar Family Choice DC reimbursement policies. The Payment Integrity team works to identify, recover and prevent inaccurate, erroneous and/or fraudulent claims payments through numerous activities during the life cycle of a claim. For example, MedStar Family Choice DC engages in subrogation activities, coordination of benefits, activities to detect and identify erroneous payments, improper payments, duplicate payments and/or overpayments, hospital billing audits, readmission audits, data mining in an effort to confirm compliance with enrollment requirements, payment policies, coding/ billing rules and/or provider contracts and activities to detect fraud, waste and abuse. Please refer to Provider Alerts for additional information on vendors and audit processes.

Payment Integrity Reviews

MedStar Family Choice, in partnership with several Payment Integrity vendors, conduct prospective (pre-payment) and retrospective (post-payment) claim reviews, including high-dollar inpatient Medical Bill Review (MBR) and Itemized Bill Review (IBR) reviews, which include edits based on guidance from the Centers for Medicare & Medicaid Services (CMS) Coverage Policies and National Coverage Determinations (NCD). Post payment MBR and IBR services consist of a one-time look back period up to 36 months from the date of the payment.

MBR/IBR Post PayProcess

- The Payment Integrity vendor will contact the provider to request the itemized bill (IB) or medical record (MR) forreview.
- Providers will have 60 days to submit the requested documentation.
- If a discrepancy is found, the Payment Integrity vendor will send an overpayment letter and findings summary notifying the provider of the error(s) and applicable overpayment amount.
- The provider will have 30 days to request clarification or submit additional documentation to the Payment Integrity vendor before the claim is set up for adjustment.
- If the provider fails to submit documentation within the allotted 60 days, the claim will result in a technical denial, and the entire payment will be retracted until the requested documentation is received and reviewed.

In addition to the findings letter and summary, all claims that are set up for recoupment will auto generate an overpayment letter indicating the reason for the overpayment and the option for facilities/providers to submit a refund check. If a check is not received within 30 days from the date of the overpayment letter, the overpayment amount will be offset from future claims.

MBR/IBR Pre PayProcess

- The Payment Integrity vendor will contact the provider to request the itemized bill (IB) or medical record (MR) forreview.
- Providers will submit the requested documentation to the respective Payment Integrity vendors for review based on the denial reason contained on the provider remit.
- The Payment Integrity vendor will review the claim and perform a review of the submitted documentation to validate accuracy and coding.

- Upon review of the documentation, the Payment Integrity vendor will submit findings to the Claims team to process the claim according to their findings.
- The claim will be adjusted, and the provider will receive payment and an explanation of payment via the remit.

Providers may follow the MedStar Family Choice payment dispute or appeals process once retractions are processed.

Excluded Providers

Medicaid and the MCOs are prohibited from paying for items or services rendered, furnished, or ordered by a provider or organization that has been excluded from the Medicare or Medicaid program. MedStar Family Choice monitors the appropriate exclusion lists on a routine basis. Providers are responsible for monitoring these lists to determine if any employees or contractors are identified.

Maryland Medicaid Sanctioned Providers List can be found here: **https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx**

Federal Exclusion Lists can be found here:

- HHS-OIG Website (List of Excluded Individuals – LEIE)
http://oig.hhs.gov/exclusions/index.asp
- General Services Administration (GSA) System for Award Management (SAM):
https://sam.gov/content/exclusions

False Claims Act Education

In addition to the Compliance Program described above, it is important that MedStar Family Choice providers understand the False Claims Act provisions for Federal and State governments. Under the Deficit Reduction Act of 2005, entities receiving $5 million or more in Medicaid funding must educate employees, contractors, and agents about Federal and State fraud and false claims laws, as well as whistle blower protections. More information on the false claims act can be found on the MedStar Family Choice website or by contacting the MedStar Family Choice Provider Relations Department.

Reporting Suspected Fraud and Abuse

Participating providers are required to report to MedStar Family Choice all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

While MedStar Family Choice monitors for possible fraud and abuse activities, MedStar Family Choice asks its providers help to eliminate fraud and abuse. Providers suspecting fraud and abuse must report this immediately by contacting MedStar Family Choice immediately. There are numerous ways in which providers can report compliance issues:

- Contact the Compliance Director at **410-933-2283**
- Contact Provider Relations at **800-905-1722**
- Contact the MedStar Health Corporate Integrity Hotline at **877-811-3411**

Providers may remain anonymous and all reports will be kept confidential. In addition, MedStar Family Choice enforces a non-retaliation policy for those individuals reporting possible compliance concerns.

You can also report provider fraud to the MDH Office of the Inspector General at **410-767- 5784** or **866-770-7175,** the Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General, at **410-576-6521** (**888-743-0023**) or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **800-HHS-TIPS** (**800-447-8477**).

The Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General created by statute to preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste, and abuse control activities for all Maryland agencies responsible for services funded by Medicaid.

Relevant Laws

There are several relevant laws that apply to fraud, waste, and abuse:

The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud and abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:

- Knowingly presenting a false or fraudulent claim for payment or approval
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government or
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The Self-Referral Prohibition Statute (Stark Law) prohibits providers from referring members to an entity with which the provider or provider's immediate family member has a financial relationship, unless an exception applies.

The Red Flag Rule (Identity Theft Protection) requires "creditors" to implement programs to identify, detect, and respond to patterns, practices, or specific activities that could indicate identity theft.

The Health Insurance Portability and Accountability Act (HIPAA) requires:

- Transaction standards;
- Minimum security requirements;
- Minimum privacy protections for protected health information; and
- National Provider Identification (NPIs) numbers.

The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812, provides Federal administrative remedies for false claims and statements, including those made to federally funded health care programs. Current civil penalties are $5,500 for each false claim or statement, and an assessment in lieu of damages sustained by the Federal government of up to double damages for each false claim for which the government makes a payment. The amount of the false claims penalty is to be adjusted periodically for inflation in accordance with a federal formula.

Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a Federal health care program, including programs for children and families accessing MedStar Family Choice services through Maryland HealthChoice.

Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C.§ 1396a(a)(68), MedStar Family Choice providers will follow Federal and Maryland laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs, including programs for children and families accessing MedStar Family Choice services through Maryland HealthChoice.

Under the Maryland False Claims Act, Md. Code Ann., Health General §2-601 et. seq. Administrative sanctions can be imposed, as follows:

- Denial or revocation of Medicare or Medicaid provider number application (if applicable);
- Suspension of provider payments;
- Being added to the OIG List of Excluded Individuals/Entities database; and
- License suspension or revocation. Remediation may include any or all of the following:
- Education;
- Administrative sanctions;
- Civil litigation and settlements;
- Criminal prosecution;
- Automatic disbarment; or
- Prison time.

Exclusion Lists & Death Master Report

MedStar Family Choice is required to check the Office of the Inspector General (OIG), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/ Entities (LEIE), the Excluded Parties List System (EPLS), the Social Security Death Master Report, and any other such databases as the Maryland MMA Providers and other Entities Sanctioned List may prescribe.

MedStar Family Choice does not participate with or enter into any provider agreement with any individual, or entity that has been excluded from participation in Federal health care programs, who have a relationship with excluded providers or who have been terminated from the Medicaid, or any programs by Maryland Department of Health for fraud, waste, or abuse. The provider must agree to assist MedStar Family Choice as necessary in meeting our obligations under the contract with the Maryland Department of Health to identify, investigate, and take appropriate corrective action against fraud, waste, and abuse (as defined in 42 C.F.R. 455.2) in the provision of health care services.

Additional Resources:

To access the current list of Maryland sanctioned providers follow this link: **health.maryland.gov/mmcp/pages/Provider-Information.aspx**

ATTACHMENT A - Rare and Expensive Case Management (REM) Program

The Maryland Department of Health (MDH) administers a Rare and Expensive Case Management (REM) program as an alternative to the MCO for certain HealthChoice eligible individuals diagnosed with rare and expensive medical conditions.

Medicaid Benefits and REM Case Management

To qualify for the REM program, the HealthChoice enrollee must have one or more of the diagnoses specified in the Rare and Expensive Disease list below. The enrollee may elect to enroll in the REM Program, or to remain in MedStar Family Choice if the Department agrees that it is medically appropriate. REM participants are eligible for all fee-for-service benefits currently offered to Medicaid- eligible beneficiaries who not eligible to enroll in MCOs. In addition REM participants may receive additional services which are described in COMAR 10.09.69.

The participant's REM case manager will:

- Gather all relevant information needed to complete a comprehensive needs assessment;
- Assist the participant select an appropriate PCP, if needed;
- Consult with a multi-disciplinary team that includes providers, participants, and family/ care givers, and develop the participant's plan of care;
- Implement the plan of care, monitor service delivery, modify the plan as warranted by changes in the participant's condition;
- Document findings and maintain clear and concise records; and
- Assist in the participant's transfer out of the REM program, when and if appropriate.

Referral and Enrollment Process

Candidates for REM are generally referred by their PCP, specialty providers, MCOs, but may also self-identify. The referral must include a physician's signature and the required supporting documentation for the qualifying diagnosis(es). A registered nurse reviews the medical information: in order to determine the member's eligibility for REM. If the intake nurse determines that there is no qualifying REM diagnosis, the application is sent to the REM physician advisor for a second level review before a denial notice is sent to the member and referral source. If the member does not meet the REM criteria, they will remain enrolled in the MCO.

If the intake nurse determines that the enrollee has a REM-qualifying diagnosis, the nurse approves the member for enrollment in REM. Before the enrollment is completed, the Intake Unit contacts the PCP to see if they will continue providing services through the Medicaid fee-for service program. If the PCP is unwilling to continue to care for the member the case is referred to a case manager to select a PCP in consultation with the member. If the PCP will continue providing services, the Intake Unit explain the program and give the member an opportunity to refuse REM enrollment. If enrollment is refused, the member remains in the MCO. The MCO is responsible for providing the member's care until the REM enrollment process is complete.

For questions and referral forms call **800-565-8190**; forms may be faxed to **410-333-5426** or mailed to:

REM Intake Unit
Maryland Department of Health 201
W. Preston Street, Room 210
Baltimore, MD 21201-2399

TABLE OF RARE AND EXPENSIVE DIAGNOSIS (CONTINUED)		
ICD10	**ICD 10 DESCRIPTION**	**AGE LIMIT**
E71.541	Zellweger-like syndrome	0-64
E71.542	Other group 3 peroxisomal disorders	0-64
E71.548	Other peroxisomal disorders	0-64
E72.01	Cystinuria	0-20
E72.02	Hartnup's disease	0-20
E72.03	Lowe's syndrome	0-20
E72.04	Cystinosis	0-20
E72.09	Other disorders of amino-acid transport	0-20
E72.11	Homocystinuria	0-20
E72.12	Methylenetetrahydrofolate reductase deficiency	0-20
E72.19	Other disorders of sulfur-bearing amino-acid metabolism	0-20
E72.20	Disorder of urea cycle metabolism, unspecified	0-20
E72.21	Argininemia	0-20
E72.22	Arginosuccinic aciduria	0-20
E72.23	Citrullinemia	0-20
E72.29	Other disorders of urea cycle metabolism	0-20
E72.3	Disorders of lysine and hydroxylysine metabolism	0-20
E72.4	Disorders of ornithine metabolism	0-20
E72.51	Non-ketotic hyperglycinemia	0-20
E72.52	Trimethylaminuria	0-20
E72.53	Primary Hyperoxaluria	0-20
E72.59	Other disorders of glycine metabolism	0-20
E72.81	Disorders of gamma aminobutyric acid metabolism	0-20
E72.89	Other specified disorders of amino-acid metabolism	0-20
E74.00	Glycogen storage disease, unspecified	0-20
E74.01	von Gierke disease	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
E74.02	Pompe disease	0-20
E74.03	Cori disease	0-20
E74.04	McArdle disease	0-20
E74.09	Other glycogen storage disease	0-20
E74.12	Hereditary fructose intolerance	0-20
E74.19	Other disorders of fructose metabolism	0-20
E74.21	Galactosemia	0-20
E74.29	Other disorders of galactose metabolism	0-20
E74.4	Disorders of pyruvate metabolism and gluconeogenesis	0-20
E75.00	GM2 gangliosidosis, unspecified	0-20
E75.01	Sandhoff disease	0-20
E75.02	Tay-Sachs disease	0-20
E75.09	Other GM2 gangliosidosis	0-20
E75.10	Unspecified gangliosidosis	0-20
E75.11	Mucolipidosis IV	0-20
E75.19	Other gangliosidosis	0-20
E75.21	Fabry (-Anderson) disease	0-20
E75.22	Gaucher disease	0-20
E75.23	Krabbe disease	0-20
E75.240	Niemann-Pick disease type A	0-20
E75.241	Niemann-Pick disease type B	0-20
E75.242	Niemann-Pick disease type C	0-20
E75.243	Niemann-Pick disease type D	0-20
E75.248	Other Niemann-Pick disease	0-20
E75.25	Metachromatic leukodystrophy	0-20
E75.26	Sulfatase deficiency	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
E75.29	Other sphingolipidosis	0-20
E75.3	Sphingolipidosis, unspecified	0-20
E75.4	Neuronal ceroid lipofuscinosis	0-20
E75.5	Other lipid storage disorders	0-20
E76.01	Hurler's syndrome	0-64
E76.02	Hurler-Scheie syndrome	0-64
E76.03	Scheie's syndrome	0-64
E76.1	Mucopolysaccharidosis, type II	0-64
E76.210	Morquio A mucopolysaccharidoses	0-64
E76.211	Morquio B mucopolysaccharidoses	0-64
E76.219	Morquio mucopolysaccharidoses, unspecified	0-64
E76.22	Sanfilippo mucopolysaccharidoses	0-64
E76.29	Other mucopolysaccharidoses	0-64
E76.3	Mucopolysaccharidosis, unspecified	0-64
E76.8	Other disorders of glucosaminoglycan metabolism	0-64
E77.0	Defects in post-translational mod of lysosomal enzymes	0-20
E77.1	Defects in glycoprotein degradation	0-20
E77.8	Other disorders of glycoprotein metabolism	0-20
E79.1	Lesch-Nyhan syndrome	0-64
E79.2	Myoadenylate deaminase deficiency	0-64
E79.8	Other disorders of purine and pyrimidine metabolism	0-64
E79.9	Disorder of purine and pyrimidine metabolism, unspecified	0-64
E80.3	Defects of catalase and peroxidase	0-64
E84.0	Cystic fibrosis with pulmonary manifestations	0-64
E84.11	Meconium ileus in cystic fibrosis	0-64
E84.19	Cystic fibrosis with other intestinal manifestations	0-64

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
E84.8	Cystic fibrosis with other manifestations	0-64
E84.9	Cystic fibrosis, unspecified	0-64
E88.40	Mitochondrial metabolism disorder, unspecified	0-64
E88.41	MELAS syndrome	0-64
E88.42	MERRF syndrome	0-64
E88.49	Other mitochondrial metabolism disorders	0-64
E88.89	Other specified metabolic disorders	0-64
F84.2	Rett's syndrome	0-20
G11.0	Congenital nonprogressive ataxia	0-20
G11.1	Early-onset cerebellar ataxia	0-20
G11.2	Late-onset cerebellar ataxia	0-20
G11.3	Cerebellar ataxia with defective DNA repair	0-20
G11.4	Hereditary spastic paraplegia	0-20
G11.8	Other hereditary ataxias	0-20
G11.9	Hereditary ataxia, unspecified	0-20
G12.0	Infantile spinal muscular atrophy, type I (Werdnig-Hoffman)	0-20
G12.1	Other inherited spinal muscular atrophy	0-20
G12.21	Amyotrophic lateral sclerosis	0-20
G12.22	Progressive bulbar palsy	0-20
G12.29	Other motor neuron disease	0-20
G12.8	Other spinal muscular atrophies and related syndromes	0-20
G12.9	Spinal muscular atrophy, unspecified	0-20
G24.1	Genetic torsion dystonia	0-64
G24.8	Other dystonia	0-64
G25.3	Myoclonus	0-5
G25.9	Extrapyramidal and movement disorder, unspecified	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
G31.81	Alpers disease	0-20
G31.82	Leigh's disease	0-20
G31.9	Degenerative disease of nervous system, unspecified	0-20
G32.81	Cerebellar ataxia in diseases classified elsewhere	0-20
G37.0	Diffuse sclerosis of central nervous system	0-64
G37.5	Concentric sclerosis (Balo) of central nervous system	0-64
G71.00	Muscular dystrophy, unspecified	0-64
G71.01	Duchenne or Becker muscular dystrophy	0-64
G71.02	Facioscapulohumeral muscular dystrophy	0-64
G71.09	Other specified muscular dystrophies	0-64
G71.11	Myotonic muscular dystrophy	0-64
G71.2	Congenital myopathies	0-64
G80.0	Spastic quadriplegic cerebral palsy	0-64
G80.1	Spastic diplegic cerebral palsy	0-20
G80.3	Athetoid cerebral palsy	0-64
G82.50	Quadriplegia, unspecified	0-64
G82.51	Quadriplegia, C1-C4 complete	0-64
G82.52	Quadriplegia, C1-C4 incomplete	0-64
G82.53	Quadriplegia, C5-C7 complete	0-64
G82.54	Quadriplegia, C5-C7 incomplete	0-64
G91.0	Communicating hydrocephalus	0-20
G91.1	Obstructive hydrocephalus	0-20
I67.5	Moyamoya disease	0-64
K91.2	Postsurgical malabsorption, not elsewhere classified	0-20
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	0-20
N03.2	Chronic nephritic syndrome w diffuse membranous glomrlneph	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
N03.3	Chronic neph syndrome w diffuse mesangial prolif glomrlneph	0-20
N03.4	Chronic neph syndrome w diffuse endocaplry prolif glomrlneph	0-20
N03.5	Chronic nephritic syndrome w diffuse mesangiocap glomrlneph	0-20
N03.6	Chronic nephritic syndrome with dense deposit disease	0-20
N03.7	Chronic nephritic syndrome w diffuse crescentic glomrlneph	0-20
N03.8	Chronic nephritic syndrome with other morphologic changes	0-20
N03.9	Chronic nephritic syndrome with unsp morphologic changes	0-20
N08	Glomerular disorders in diseases classified elsewhere	0-20
N18.1	Chronic kidney disease, stage 1	0-20
N18.2	Chronic kidney disease, stage 2 (mild)	0-20
N18.3	Chronic kidney disease, stage 3 (moderate)	0-20
N18.4	Chronic kidney disease, stage 4 (severe)	0-20
N18.5	Chronic kidney disease, stage 5	0-20
N18.6	End stage renal disease	0-20
N18.9	Chronic kidney disease, unspecified	0-20
Q01.9	Encephalocele, unspecified	0-20
Q02	Microcephaly	0-20
Q03.0	Malformations of aqueduct of Sylvius	0-20
Q03.1	Atresia of foramina of Magendie and Luschka	0-20
Q03.8	Other congenital hydrocephalus	0-20
Q03.9	Congenital hydrocephalus, unspecified	0-20
Q04.3	Other Reduction deformities of brain	0-20
Q04.5	Megalencephaly	0-20
Q04.6	Congenital cerebral cysts	0-20
Q04.8	Other specified congenital malformations of brain	0-20
Q05.0	Cervical spina bifida with hydrocephalus	0-64

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
Q05.1	Thoracic spina bifida with hydrocephalus	0-64
Q05.2	Lumbar spina bifida with hydrocephalus	0-64
Q05.3	Sacral spina bifida with hydrocephalus	0-64
Q05.4	Unspecified spina bifida with hydrocephalus	0-64
Q05.5	Cervical spina bifida without hydrocephalus	0-64
Q05.6	Thoracic spina bifida without hydrocephalus	0-64
Q05.7	Lumbar spina bifida without hydrocephalus	0-64
Q05.8	Sacral spina bifida without hydrocephalus	0-64
Q05.9	Spina bifida, unspecified	0-64
Q06.0	Amyelia	0-64
Q06.1	Hypoplasia and dysplasia of spinal cord	0-64
Q06.2	Diastematomyelia	0-64
Q06.3	Other congenital cauda equina malformations	0-64
Q06.4	Hydromyelia	0-64
Q06.8	Other specified congenital malformations of spinal cord	0-64
Q07.01	Arnold-Chiari syndrome with spina bifida	0-64
Q07.02	Arnold-Chiari syndrome with hydrocephalus	0-64
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus	0-64
Q30.1	Agenesis and underdevelopment of nose, cleft or absent nose only	0-5
Q30.2	Fissured, notched and cleft nose, cleft or absent nose only	0-5
Q31.0	Web of larynx	0-20
Q31.8	Other congenital malformations of larynx, atresia or agenesis of larynx only	0-20
Q32.1	Other congenital malformations of trachea, atresia or agenesis of trachea only	0-20
Q32.4	Other congenital malformations of bronchus, atresia or agenesis of bronchus only	0-20
Q33.0	Congenital cystic lung	0-20
Q33.2	Sequestration of lung	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
Q33.3	Agenesis of lung	0-20
Q33.6	Congenital hypoplasia and dysplasia of lung	0-20
Q35.1	Cleft hard palate	0-20
Q35.3	Cleft soft palate	0-20
Q35.5	Cleft hard palate with cleft soft palate	0-20
Q35.9	Cleft palate, unspecified	0-20
Q37.0	Cleft hard palate with bilateral cleft lip	0-20
Q37.1	Cleft hard palate with unilateral cleft lip	0-20
Q37.2	Cleft soft palate with bilateral cleft lip	0-20
Q37.3	Cleft soft palate with unilateral cleft lip	0-20
Q37.4	Cleft hard and soft palate with bilateral cleft lip	0-20
Q37.5	Cleft hard and soft palate with unilateral cleft lip	0-20
Q37.8	Unspecified cleft palate with bilateral cleft lip	0-20
Q37.9	Unspecified cleft palate with unilateral cleft lip	0-20
Q39.0	Atresia of esophagus without fistula	0-3
Q39.1	Atresia of esophagus with tracheo-esophageal fistula	0-3
Q39.2	Congenital tracheo-esophageal fistula without atresia	0-3
Q39.3	Congenital stenosis and stricture of esophagus	0-3
Q39.4	Esophageal web	0-3
Q42.0	Congenital absence, atresia and stenosis of rectum with fistula	0-5
Q42.1	Congen absence, atresia and stenosis of rectum without fistula	0-5
Q42.2	Congenital absence, atresia and stenosis of anus with fistula	0-5
Q42.3	Congenital absence, atresia and stenosis of anus without fistula	0-5
Q42.8	Congenital absence, atresia and stenosis of other parts of large intestine	0-5
Q42.9	Congenital absence, atresia and stenosis of large intestine, part unspecified	0-5
Q43.1	Hirschsprung's disease	0-15

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
Q44.2	Atresia of bile ducts	0-20
Q44.3	Congenital stenosis and stricture of bile ducts	0-20
Q44.6	Cystic disease of liver	0-20
Q45.0	Agenesis, aplasia and hypoplasia of pancreas	0-5
Q45.1	Annular pancreas	0-5
Q45.3	Other congenital malformations of pancreas and pancreatic duct	0-5
Q45.8	Other specified congenital malformations of digestive system	0-10
Q60.1	Renal agenesis, bilateral	0-20
Q60.4	Renal hypoplasia, bilateral	0-20
Q60.6	Potter's syndrome, with bilateral renal agenesis only	0-20
Q61.02	Congenital multiple renal cysts, bilateral only	0-20
Q61.19	Other polycystic kidney, infantile type, bilateral only	0-20
Q61.2	Polycystic kidney, adult type, bilateral only	0-20
Q61.3	Polycystic kidney, unspecified, bilateral only	0-20
Q61.4	Renal dysplasia, bilateral only	0-20
Q61.5	Medullary cystic kidney, bilateral only	0-20
Q61.9	Cystic kidney disease, unspecified, bilateral only	0-20
Q64.10	Exstrophy of urinary bladder, unspecified	0-20
Q64.12	Cloacal extrophy of urinary bladder	0-20
Q64.19	Other exstrophy of urinary bladder	0-20
Q75.0	Craniosynostosis	0-20
Q75.1	Craniofacial dysostosis	0-20
Q75.2	Hypertelorism	0-20
Q75.4	Mandibulofacial dysostosis	0-20
Q75.5	Oculomandibular dysostosis	0-20
Q75.8	Other congenital malformations of skull and face bones	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
Q77.4	Achondroplasia	0-1
Q77.6	Chondroectodermal dysplasia	0-1
Q77.8	Other osteochondrodysplasia with defects of growth of tubular bones and spine	0-1
Q78.0	Osteogenesis imperfecta	0-20
Q78.1	Polyostotic fibrous dysplasia	0-1
Q78.2	Osteopetrosis	0-1
Q78.3	Progressive diaphyseal dysplasia	0-1
Q78.4	Enchondromatosis	0-1
Q78.6	Multiple congenital exostoses	0-1
Q78.8	Other specified osteochondrodysplasias	0-1
Q78.9	Osteochondrodysplasia, unspecified	0-1
Q79.0	Congenital diaphragmatic hernia	0-1
Q79.1	Other congenital malformations of diaphragm	0-1
Q79.2	Exomphalos	0-1
Q79.3	Gastroschisis	0-1
Q79.4	Prune belly syndrome	0-1
Q79.59	Other congenital malformations of abdominal wall	0-1
Q89.7	Multiple congenital malformations, not elsewhere classified	0-10
R75	Inconclusive laboratory evidence of HIV	0-12 months
Z21	Asymptomatic human immunodeficiency virus infection status	0-20
Z99.11	Dependence on respirator (ventilator) status	1-64
Z99.2	Dependence on renal dialysis	21-64

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
E71.541	Zellweger-like syndrome	0-64
E71.542	Other group 3 peroxisomal disorders	0-64
E71.548	Other peroxisomal disorders	0-64
E72.01	Cystinuria	0-20
E72.02	Hartnup's disease	0-20
E72.03	Lowe's syndrome	0-20
E72.04	Cystinosis	0-20
E72.09	Other disorders of amino-acid transport	0-20
E72.11	Homocystinuria	0-20
E72.12	Methylenetetrahydrofolate reductase deficiency	0-20
E72.19	Other disorders of sulfur-bearing amino-acid metabolism	0-20
E72.20	Disorder of urea cycle metabolism, unspecified	0-20
E72.21	Argininemia	0-20
E72.22	Arginosuccinic aciduria	0-20
E72.23	Citrullinemia	0-20
E72.29	Other disorders of urea cycle metabolism	0-20
E72.3	Disorders of lysine and hydroxylysine metabolism	0-20
E72.4	Disorders of ornithine metabolism	0-20
E72.51	Non-ketotic hyperglycinemia	0-20
E72.52	Trimethylaminuria	0-20
E72.53	Primary Hyperoxaluria	0-20
E72.59	Other disorders of glycine metabolism	0-20
E72.81	Disorders of gamma aminobutyric acid metabolism	0-20
E72.89	Other specified disorders of amino-acid metabolism	0-20
E74.00	Glycogen storage disease, unspecified	0-20
E74.01	von Gierke disease	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
E74.02	Pompe disease	0-20
E74.03	Cori disease	0-20
E74.04	McArdle disease	0-20
E74.09	Other glycogen storage disease	0-20
E74.12	Hereditary fructose intolerance	0-20
E74.19	Other disorders of fructose metabolism	0-20
E74.21	Galactosemia	0-20
E74.29	Other disorders of galactose metabolism	0-20
E74.4	Disorders of pyruvate metabolism and gluconeogenesis	0-20
E75.00	GM2 gangliosidosis, unspecified	0-20
E75.01	Sandhoff disease	0-20
E75.02	Tay-Sachs disease	0-20
E75.09	Other GM2 gangliosidosis	0-20
E75.10	Unspecified gangliosidosis	0-20
E75.11	Mucolipidosis IV	0-20
E75.19	Other gangliosidosis	0-20
E75.21	Fabry (-Anderson) disease	0-20
E75.22	Gaucher disease	0-20
E75.23	Krabbe disease	0-20
E75.240	Niemann-Pick disease type A	0-20
E75.241	Niemann-Pick disease type B	0-20
E75.242	Niemann-Pick disease type C	0-20
E75.243	Niemann-Pick disease type D	0-20
E75.248	Other Niemann-Pick disease	0-20
E75.25	Metachromatic leukodystrophy	0-20
E75.26	Sulfatase deficiency	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
E75.29	Other sphingolipidosis	0-20
E75.3	Sphingolipidosis, unspecified	0-20
E75.4	Neuronal ceroid lipofuscinosis	0-20
E75.5	Other lipid storage disorders	0-20
E76.01	Hurler's syndrome	0-64
E76.02	Hurler-Scheie syndrome	0-64
E76.03	Scheie's syndrome	0-64
E76.1	Mucopolysaccharidosis, type II	0-64
E76.210	Morquio A mucopolysaccharidoses	0-64
E76.211	Morquio B mucopolysaccharidoses	0-64
E76.219	Morquio mucopolysaccharidoses, unspecified	0-64
E76.22	Sanfilippo mucopolysaccharidoses	0-64
E76.29	Other mucopolysaccharidoses	0-64
E76.3	Mucopolysaccharidosis, unspecified	0-64
E76.8	Other disorders of glucosaminoglycan metabolism	0-64
E77.0	Defects in post-translational mod of lysosomal enzymes	0-20
E77.1	Defects in glycoprotein degradation	0-20
E77.8	Other disorders of glycoprotein metabolism	0-20
E79.1	Lesch-Nyhan syndrome	0-64
E79.2	Myoadenylate deaminase deficiency	0-64
E79.8	Other disorders of purine and pyrimidine metabolism	0-64
E79.9	Disorder of purine and pyrimidine metabolism, unspecified	0-64
E80.3	Defects of catalase and peroxidase	0-64
E84.0	Cystic fibrosis with pulmonary manifestations	0-64
E84.11	Meconium ileus in cystic fibrosis	0-64
E84.19	Cystic fibrosis with other intestinal manifestations	0-64

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
E84.8	Cystic fibrosis with other manifestations	0-64
E84.9	Cystic fibrosis, unspecified	0-64
E88.40	Mitochondrial metabolism disorder, unspecified	0-64
E88.41	MELAS syndrome	0-64
E88.42	MERRF syndrome	0-64
E88.49	Other mitochondrial metabolism disorders	0-64
E88.89	Other specified metabolic disorders	0-64
F84.2	Rett's syndrome	0-20
G11.0	Congenital nonprogressive ataxia	0-20
G11.1	Early-onset cerebellar ataxia	0-20
G11.2	Late-onset cerebellar ataxia	0-20
G11.3	Cerebellar ataxia with defective DNA repair	0-20
G11.4	Hereditary spastic paraplegia	0-20
G11.8	Other hereditary ataxias	0-20
G11.9	Hereditary ataxia, unspecified	0-20
G12.0	Infantile spinal muscular atrophy, type I (Werdnig-Hoffman)	0-20
G12.1	Other inherited spinal muscular atrophy	0-20
G12.21	Amyotrophic lateral sclerosis	0-20
G12.22	Progressive bulbar palsy	0-20
G12.29	Other motor neuron disease	0-20
G12.8	Other spinal muscular atrophies and related syndromes	0-20
G12.9	Spinal muscular atrophy, unspecified	0-20
G24.1	Genetic torsion dystonia	0-64
G24.8	Other dystonia	0-64
G25.3	Myoclonus	0-5
G25.9	Extrapyramidal and movement disorder, unspecified	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
G31.81	Alpers disease	0-20
G31.82	Leigh's disease	0-20
G31.9	Degenerative disease of nervous system, unspecified	0-20
G32.81	Cerebellar ataxia in diseases classified elsewhere	0-20
G37.0	Diffuse sclerosis of central nervous system	0-64
G37.5	Concentric sclerosis (Balo) of central nervous system	0-64
G71.00	Muscular dystrophy, unspecified	0-64
G71.01	Duchenne or Becker muscular dystrophy	0-64
G71.02	Facioscapulohumeral muscular dystrophy	0-64
G71.09	Other specified muscular dystrophies	0-64
G71.11	Myotonic muscular dystrophy	0-64
G71.2	Congenital myopathies	0-64
G80.0	Spastic quadriplegic cerebral palsy	0-64
G80.1	Spastic diplegic cerebral palsy	0-20
G80.3	Athetoid cerebral palsy	0-64
G82.50	Quadriplegia, unspecified	0-64
G82.51	Quadriplegia, C1-C4 complete	0-64
G82.52	Quadriplegia, C1-C4 incomplete	0-64
G82.53	Quadriplegia, C5-C7 complete	0-64
G82.54	Quadriplegia, C5-C7 incomplete	0-64
G91.0	Communicating hydrocephalus	0-20
G91.1	Obstructive hydrocephalus	0-20
I67.5	Moyamoya disease	0-64
K91.2	Postsurgical malabsorption, not elsewhere classified	0-20
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	0-20
N03.2	Chronic nephritic syndrome w diffuse membranous glomrlneph	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
N03.3	Chronic neph syndrome w diffuse mesangial prolif glomrlneph	0-20
N03.4	Chronic neph syndrome w diffuse endocaplry prolif glomrlneph	0-20
N03.5	Chronic nephritic syndrome w diffuse mesangiocap glomrlneph	0-20
N03.6	Chronic nephritic syndrome with dense deposit disease	0-20
N03.7	Chronic nephritic syndrome w diffuse crescentic glomrlneph	0-20
N03.8	Chronic nephritic syndrome with other morphologic changes	0-20
N03.9	Chronic nephritic syndrome with unsp morphologic changes	0-20
N08	Glomerular disorders in diseases classified elsewhere	0-20
N18.1	Chronic kidney disease, stage 1	0-20
N18.2	Chronic kidney disease, stage 2 (mild)	0-20
N18.3	Chronic kidney disease, stage 3 (moderate)	0-20
N18.4	Chronic kidney disease, stage 4 (severe)	0-20
N18.5	Chronic kidney disease, stage 5	0-20
N18.6	End stage renal disease	0-20
N18.9	Chronic kidney disease, unspecified	0-20
Q01.9	Encephalocele, unspecified	0-20
Q02	Microcephaly	0-20
Q03.0	Malformations of aqueduct of Sylvius	0-20
Q03.1	Atresia of foramina of Magendie and Luschka	0-20
Q03.8	Other congenital hydrocephalus	0-20
Q03.9	Congenital hydrocephalus, unspecified	0-20
Q04.3	Other Reduction deformities of brain	0-20
Q04.5	Megalencephaly	0-20
Q04.6	Congenital cerebral cysts	0-20
Q04.8	Other specified congenital malformations of brain	0-20
Q05.0	Cervical spina bifida with hydrocephalus	0-64

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
Q05.1	Thoracic spina bifida with hydrocephalus	0-64
Q05.2	Lumbar spina bifida with hydrocephalus	0-64
Q05.3	Sacral spina bifida with hydrocephalus	0-64
Q05.4	Unspecified spina bifida with hydrocephalus	0-64
Q05.5	Cervical spina bifida without hydrocephalus	0-64
Q05.6	Thoracic spina bifida without hydrocephalus	0-64
Q05.7	Lumbar spina bifida without hydrocephalus	0-64
Q05.8	Sacral spina bifida without hydrocephalus	0-64
Q05.9	Spina bifida, unspecified	0-64
Q06.0	Amyelia	0-64
Q06.1	Hypoplasia and dysplasia of spinal cord	0-64
Q06.2	Diastematomyelia	0-64
Q06.3	Other congenital cauda equina malformations	0-64
Q06.4	Hydromyelia	0-64
Q06.8	Other specified congenital malformations of spinal cord	0-64
Q07.01	Arnold-Chiari syndrome with spina bifida	0-64
Q07.02	Arnold-Chiari syndrome with hydrocephalus	0-64
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus	0-64
Q30.1	Agenesis and underdevelopment of nose, cleft or absent nose only	0-5
Q30.2	Fissured, notched and cleft nose, cleft or absent nose only	0-5
Q31.0	Web of larynx	0-20
Q31.8	Other congenital malformations of larynx, atresia or agenesis of larynx only	0-20
Q32.1	Other congenital malformations of trachea, atresia or agenesis of trachea only	0-20
Q32.4	Other congenital malformations of bronchus, atresia or agenesis of bronchus only	0-20
Q33.0	Congenital cystic lung	0-20
Q33.2	Sequestration of lung	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
Q33.3	Agenesis of lung	0-20
Q33.6	Congenital hypoplasia and dysplasia of lung	0-20
Q35.1	Cleft hard palate	0-20
Q35.3	Cleft soft palate	0-20
Q35.5	Cleft hard palate with cleft soft palate	0-20
Q35.9	Cleft palate, unspecified	0-20
Q37.0	Cleft hard palate with bilateral cleft lip	0-20
Q37.1	Cleft hard palate with unilateral cleft lip	0-20
Q37.2	Cleft soft palate with bilateral cleft lip	0-20
Q37.3	Cleft soft palate with unilateral cleft lip	0-20
Q37.4	Cleft hard and soft palate with bilateral cleft lip	0-20
Q37.5	Cleft hard and soft palate with unilateral cleft lip	0-20
Q37.8	Unspecified cleft palate with bilateral cleft lip	0-20
Q37.9	Unspecified cleft palate with unilateral cleft lip	0-20
Q39.0	Atresia of esophagus without fistula	0-3
Q39.1	Atresia of esophagus with tracheo-esophageal fistula	0-3
Q39.2	Congenital tracheo-esophageal fistula without atresia	0-3
Q39.3	Congenital stenosis and stricture of esophagus	0-3
Q39.4	Esophageal web	0-3
Q42.0	Congenital absence, atresia and stenosis of rectum with fistula	0-5
Q42.1	Congen absence, atresia and stenosis of rectum without fistula	0-5
Q42.2	Congenital absence, atresia and stenosis of anus with fistula	0-5
Q42.3	Congenital absence, atresia and stenosis of anus without fistula	0-5
Q42.8	Congenital absence, atresia and stenosis of other parts of large intestine	0-5
Q42.9	Congenital absence, atresia and stenosis of large intestine, part unspecified	0-5
Q43.1	Hirschsprung's disease	0-15

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
Q44.2	Atresia of bile ducts	0-20
Q44.3	Congenital stenosis and stricture of bile ducts	0-20
Q44.6	Cystic disease of liver	0-20
Q45.0	Agenesis, aplasia and hypoplasia of pancreas	0-5
Q45.1	Annular pancreas	0-5
Q45.3	Other congenital malformations of pancreas and pancreatic duct	0-5
Q45.8	Other specified congenital malformations of digestive system	0-10
Q60.1	Renal agenesis, bilateral	0-20
Q60.4	Renal hypoplasia, bilateral	0-20
Q60.6	Potter's syndrome, with bilateral renal agenesis only	0-20
Q61.02	Congenital multiple renal cysts, bilateral only	0-20
Q61.19	Other polycystic kidney, infantile type, bilateral only	0-20
Q61.2	Polycystic kidney, adult type, bilateral only	0-20
Q61.3	Polycystic kidney, unspecified, bilateral only	0-20
Q61.4	Renal dysplasia, bilateral only	0-20
Q61.5	Medullary cystic kidney, bilateral only	0-20
Q61.9	Cystic kidney disease, unspecified, bilateral only	0-20
Q64.10	Exstrophy of urinary bladder, unspecified	0-20
Q64.12	Cloacal extrophy of urinary bladder	0-20
Q64.19	Other exstrophy of urinary bladder	0-20
Q75.0	Craniosynostosis	0-20
Q75.1	Craniofacial dysostosis	0-20
Q75.2	Hypertelorism	0-20
Q75.4	Mandibulofacial dysostosis	0-20
Q75.5	Oculomandibular dysostosis	0-20
Q75.8	Other congenital malformations of skull and face bones	0-20

Table of Rare and Expensive Diagnosis (continued)		
ICD10	ICD 10 DESCRIPTION	AGE LIMIT
Q77.4	Achondroplasia	0-1
Q77.6	Chondroectodermal dysplasia	0-1
Q77.8	Other osteochondrodysplasia with defects of growth of tubular bones and spine	0-1
Q78.0	Osteogenesis imperfecta	0-20
Q78.1	Polyostotic fibrous dysplasia	0-1
Q78.2	Osteopetrosis	0-1
Q78.3	Progressive diaphyseal dysplasia	0-1
Q78.4	Enchondromatosis	0-1
Q78.6	Multiple congenital exostoses	0-1
Q78.8	Other specified osteochondrodysplasias	0-1
Q78.9	Osteochondrodysplasia, unspecified	0-1
Q79.0	Congenital diaphragmatic hernia	0-1
Q79.1	Other congenital malformations of diaphragm	0-1
Q79.2	Exomphalos	0-1
Q79.3	Gastroschisis	0-1
Q79.4	Prune belly syndrome	0-1
Q79.59	Other congenital malformations of abdominal wall	0-1
Q89.7	Multiple congenital malformations, not elsewhere classified	0-10
R75	Inconclusive laboratory evidence of HIV	0-12 months
Z21	Asymptomatic human immunodeficiency virus infection status	0-20
Z99.11	Dependence on respirator (ventilator) status	1-64
Z99.2	Dependence on renal dialysis	21-64

ATTACHMENT B - School Based Health Center Visitor Report

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

☐ **Well child exam only (see attached physical exam form)**

SBHC Name & Address: **SBHC Provider Number:** **Contact Name:** **Telephone:** **Fax:**	**MCO Name & Address:** **Contact Name:** **Telephone:** **Fax:** **Date Faxed:**	
Student Name: **DOB:** **MA Number:** **SS Number:**	**Date of Visit:** **Type of Visit:** ☐ **Acute/Urgent** ☐ **Follow Up** ☐ **Health Maintenance**	**ICD-10 Codes**
Provider Name/Title:		**CPT Codes**
T: Hgt: Rapid Strep Test: - P: Wgt: Hgb: RR: BMI: BGL: BP: U/A: PF: PaO2:	**Drug Allergy:** ☐ **NKDA**	
	Current Medications:	**Immunization review:** ☐ **UTD** **Given today:** **Needs:**

Age: **Chief Complaint:**
HPI:

Past Medical History: ☐ **Unremarkable** ☐ **See health history** ☐ **Pertinent:**

Physical Findings:

General: ☐ Alert/NAD
☐ Pertinent:

Head: ☐ Normal
☐ Pertinent:

Ears: ☐ TMs: pearly, + landmarks , + light reflex
☐ Cerumen removed curette/lavage
☐ Pertinent**:**

Eyes: ☐ PERRLA, sclerae clear, no discharge/crusting
☐ Pertinent:

Nose: ☐ Turbinates: pink, without swelling
☐ Pertinent:

Mouth: ☐ Pharynx without erythema, swelling, or exudate
☐ Normal dentition without caries
☐ Pertinent:

Neck: ☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: ☐ No lymphadenopathy
☐ Pertinent:

Cardiac: ☐ RRR, normal S1 S2, no murmur
☐ Pertinent:

Lungs: ☐ CTA bilaterally, no retractions, wheezes, rales, ronchi
☐ Pertinent:

Abdomen: ☐ Soft, non-tender, no HSM, no masses,
☐ Bowel sounds present
☐ Pertinent:

Genitalia: ☐ Normal female/normal male Tanner Stage
☐ Pertinent:

Extremities: ☐ FROM
☐ Pertinent:

Neurologic: ☐ Grossly intact
☐ Pertinent:

Skin: ☐ Intact, no rashes
☐ Pertinent:

ASSESSMENT: **PLAN:**

Rx Ordered:

Labs Ordered:

Radiology Services Ordered:

PCP F/U Required:
☐ **Yes** ☐ **No**

Provider Signature: _____

IMH 2015 **For MCO formulary info, find MCO website at:** https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/Home.aspx

ATTACHMENT C - Local Health ACCU and NEMT Transportation – Contact List

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	http://health.maryland.gov/allegany/ Pages/ Home.aspx
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	http://www.aahealth.org/
Baltimore City	410-396-4398	410-396-7633	410-649-0521	http://health.baltimorecity.gov/
Baltimore County	410-887-2243	410-887-2828	410-887-4381	http://www.baltimorecountymd. gov/agencies/ health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext. 360	http://www.calverthealth.org/
Caroline	410-479-8000	410-479-8014	410-479-8189	https://www.carolinehd.org/home
Carroll	410-876-2152	410-876-4813	410-876-4941	http://cchd.maryland.gov/
Cecil	410-996-5550	410-996-5171	410-996-5130	http://www.cecilcountyhealth.org
Charles	301-609-6900	301-609-6923	301-609-6760	http://www.charlescountyhealth.org/
Dorchester	410-228-3223	410-901-2426	410-901-8167	http://www.dorchesterhealth.org/
Frederick	301-600-1029	301-600-3124	301-600-3124	http://health.frederickcountymd.gov/
Garrett	301-334-7777	301-334-7727	301-334-7771	http://garretthealth.org/
Harford	410-838-1500	410-638-1671	410-942-7999	http://harfordcountyhealth.com/
Howard	410-313-6300	877-312-6571	410-313-7323	https://www.howardcountymd.gov/ Departments/ Health
Kent	410-778-1350	410-778-7025	410-778-7035	http://kenthd.org/
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1635	http://www.montgomerycountymd. gov/hhs/
Prince George's	301-883-7879	301-856-9555	301-856-9550	http://www.princegeorgescountymd. gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4456	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-4330	http://www.smchd.org/
Somerset	443-523-1700	443-523-1722	443-523-1758	http://somersethealth.org/
Talbot	410-819-5600	410-819-5609	410-819-5600	https://health.maryland.gov/ talbotcounty/Pages/home.aspx
Washington	240-313-3200	240-313-3264	240-313-3229	https://health.maryland.gov/washhealth
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	https://www.wicomicohealth.org/
Worcester	410-632-1100	410-632-0092	410-629-0614	http://www.worcesterhealth.org/

ATTACHMENT D - Local Health Services Request Form

Date: / /
To:
Attention:
Address:
City/State/Zip:
Phone:

HealthChoice
LOCAL HEALTH SERVICES REQUEST FORM

Client Information	
Client Name: Address: City/State/Zip: Phone: County: DOB: / / SS#: - - Sex: M F Hispanic: Y N MA#: Private Ins.: No Yes Martial Status: Single Married Unknown If Interpreter is needed specific language:	Race: ☐ African-American/Black ☐ Alaskan Native ☐ American Native ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ More than one race ☐ Unknown Caregiver/Emergency Contact: Relationship: Phone:
FOLLOW-UP FOR: (Check all that apply) Child under 2 years of age Child 2 – 21 years of age Child with special health care needs Pregnant EDD:____/____/____ Adults with disability(mental, physical, or developmental) Substance use care needed Homeless (at-risk)	RELATED TO: (Check all that apply) Missed appointments:____#missed Adherence to plan of care Immunization delay Preventable hospitalization Transportation Other:
Diagnosis:	
Comments:	

MCO:	Date Received: / /
Document Outreach: # Letter(s)_____ # Phone Call(s) _____ # Face to Face _____	Unable to Locate Contact Date: / / Advised Refused
Comments:	
Contact Person: Phone: Fax:	Provider Name: Provider Phone:

Local Health Department (County)	Date Received: / /
Document Outreach: # Letter(s)_____ # Phone Call(s) _____ # Face to Face _____	No Action (returned) Reason for return:
Contact Person: Contact Phone:	Disposition: Contact Complete: Date: / / Unable to Locate: Date: / / Referred to: Date: / /
Comments:	

MedStarFamilyChoiceMD.com

MedStar Family Choice

10980 Grantchester Way
5th Floor
Columbia, MD 21044
888-404-3549 PHONE

MFCMD-12225