



MedStar Family
Choice



Provider Newsletter

3rd Quarter 2026



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Coordination of care is important

The goal of care coordination is to organize care and share relevant information among all providers involved with a particular patient to achieve safer and more effective care. Information sharing is crucial when patients transition between different aspects of the health care system, for example, transitions across settings such as primary care, specialty care as well as emergency department and/or inpatient settings.

To ensure effective care coordination for our members, we want to remind all providers taking part in a MedStar Family Choice member's care, to refer any assessments, results, and/or recommendations to the member's primary care provider (PCP). Additionally, any referrals to other providers should include the name of the member's PCP.

MedStar Family Choice offers several programs to assist with member coordination of care. For more information regarding specific care coordination programs and assistance please call MedStar Family Choice Care Management at **800-905-1722**, option 2.

MedStar Family Choice Quality, Outreach, and Provider Relations departments continuously work with providers and members to improve this process. Please feel free to contact our Provider Relations department at mfc-providerrelations2@medstar.net or **800-261-3371** with any comments, questions, and/or recommendations.

Other Resources: Agency for Healthcare Research and Quality Care coordination — [AHRQ.gov/NCEPCR/Care/Coordination.html](https://www.AHRQ.gov/NCEPCR/Care/Coordination.html)



Update to the MedStar Family Choice formulary

MedStar Family Choice must render a decision and complete notification for all pharmacy prior authorization requests within twenty-four (24) hours of receipt, given that all clinical information were submitted. In case the necessary information is not received before the initial 24-hour timeframe, a 14-day extension may be granted to allow time for the provider to send in any documentation or information. MedStar Family Choice will continue to reach out for clinical and documentation during the 14-day extension. If the clinical is not received upon the expiration date a decision will be made following the regular review process.

Please check the MedStar Family Choice Formulary and Pharmacy Prior Auth on our website prior to submitting your request. To comply with this stringent turnaround time, we ask that your office provide complete clinical information at the time of original submission to avoid denials for incomplete requests.

To access the forms, please visit [MedStarFamilyChoiceMD.com/Maryland-Providers/Pharmacy-Prescription-Information](https://www.MedStarFamilyChoiceMD.com/Maryland-Providers/Pharmacy-Prescription-Information)

Friendly reminder that drugs prescribed for weight management are not a covered benefit as outlined in MedStar Pharmacy Policy 209: Pharmacy Benefits Management, Section 1.3.1.1.

FORMULARY CHANGES:

- Formulary removals effective 01/1/26:
 - Ajoy, Orenitram ER, Trulicity, all non-Unifine brand pen needles
- Additions / Changes to prior authorization effective 04/01/2026:
 - Zidovudine (AZT) (generic of RETROVIR) syrup (10mg/ml) - Age limit added; no PA required for infants under 2 months (under 2 months old)

PRIOR AUTHORIZATION UPDATES: EFFECTIVE ON OR AROUND MAY 13, 2026

- Formulary additions with prior authorization
 - Xeljanz; Entyvio; Otezla; Humira Biosimilars
- Updated Prior Authorization Criteria:
 - Cosentyx; Stelara Biosimilars; Enbrel; Dupixent

UTILIZATION MANAGEMENT: CHANGES EFFECTIVE ON OR AROUND JUNE 1, 2026

- Managed Drug Limitations; Step Therapy Requirements
 - Ozempic (semaglutide injection); Ozempic (semaglutide tablet); Rybelsus (semaglutide tablet); Mounjaro (tirzepatide injection)

Prior Authorization Guide Updates for August 2026

MedStar Family Choice has updated the Quick Authorization Guide to include several new procedures and medications administered in the office or at an infusion center that now require prior authorization as of August 2026. Providers are encouraged to review the most current version of the Quick Authorization Guide before rendering services or ordering one of these drugs to ensure authorization requirements are met.

Please visit our Provider Preauthorization and Utilization Management webpage to access the latest Quick Authorization Guide: <https://www.medstarfamilychoicemd.com/maryland-providers/utilization-management>

Checking the guide regularly will help ensure compliance with current prior authorization requirements and prevent delays in member care and claims processing.

How to request second opinions with out-of-network providers

On occasion, MedStar Family Choice members may request to seek a second medical opinion. Members have the right to do so and should be referred to a different in-network provider by his/her primary care physician (PCP). If an in-network provider is not available to provide a second opinion, an out-of-network provider can be requested. The member's PCP should work with the patient, as well as the MedStar Family Choice Care Management department, when a second opinion must be scheduled with an out-of-network provider. A referral from the member's PCP, along with a prior authorization from Care Management, prior to the member's appointment with the nonparticipating physician, is required.

Prior authorization can be obtained by faxing a Maryland Uniform Referral form or the MedStar Family Choice prior authorization template to MedStar Family Choice Care Management at **410-933-2274** or by calling **800-905-1722**, option 2.

Learn more about provider credentialing and recredentialing

Accurate and timely provider data is essential to keeping MedStar Family Choice's credentialing system running smoothly. MedStar Family Choice's credentialing system helps to develop directories and assists with paying claims. Collecting and maintaining accurate provider data can be challenging, which is why we rely on providers to keep their CAQH online application up to date. In addition, MedStar Family Choice providers are required to comply with the following:

- Providers shall immediately notify MedStar Family Choice of any changes in the status of licensure (i.e., suspended, revoked, surrendered, new licensure number, etc.).
- Providers shall maintain a valid and current license to practice at all times.
- DEA or CDS Certificates applies to providers who are qualified to write prescriptions, and providers must also maintain a valid and current certificate at all times.
- Every 120 days practitioners must re-attest that their CAQH online application is correct.

- Providers will notify MedStar Family Choice of the suspension, loss, or reduction of hospital privileges.
- Providers must enroll with the state Medicaid agency and maintain an active Fee-for-Service (FFS) provider number.

CAQH Benefits to Providers

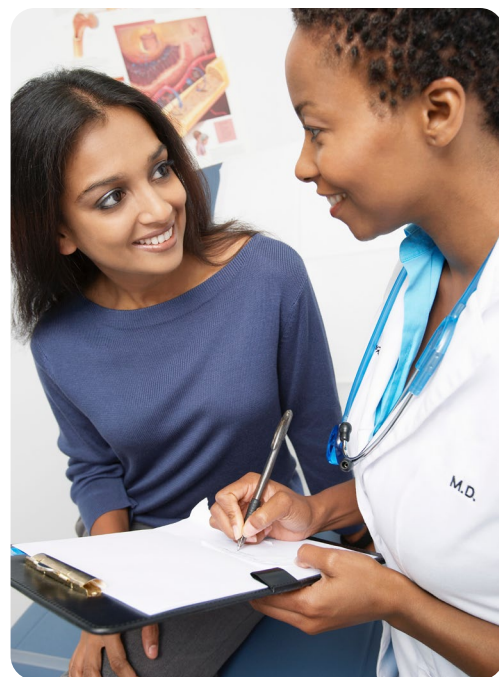
- Free service to providers.
- Easy to use.
- Enter, submit, and store all data electronically.
- Eliminates the need for time-consuming paper forms.
- Enhanced security features help you maintain total control of your information.
- Re-attest in minutes.
- Updated information is immediately available to organizations authorized by the provider.
- Upload supporting documents directly into CAQH to eliminate the need for manual submission, and to improve the timeliness of completed applications.

Schedule annual physicals

Annual physical versus sports physical

On occasion, MedStar Family Choice members may request to seek a second medical opinion. Members have the right to do so and should be referred to a different in-network provider by his/ her primary care physician (PCP). If an in-network provider is not available to provide a second opinion, an out-of-network provider can be requested. The member's PCP should work with the patient, as well as the MedStar Family Choice Care Management department, when a second opinion must be scheduled with an out-of-network provider. A referral from the member's PCP, along with a prior authorization from Care Management, prior to the member's appointment with the nonparticipating physician, is required.

Prior authorization can be obtained by faxing a Maryland Uniform Referral form or the MedStar Family Choice prior authorization template to MedStar Family Choice Care Management at **410-933-2274** or by calling **800-905-1722**.





Stay Ahead of Flu Season

The season has changed and summer is over and we welcome fall. The leaves will change color, and the air will turn crisp. We must remember that flu season is upon us. Here are some tips to help you stay healthy and flu-free this fall.

1. Get Vaccinated

- Get your flu shot every year. Each year the shot is updated for the flu virus suspected this year.
- Everyone ages 6 months and older should get the flu vaccine. Especially if you have a risk for complications- young children, pregnant persons, older adults, people with chronic health problems.

2. Practice Good Hygiene

- Hand Washing- Wash your hands with soap and water for at least 20 seconds.
- Cover coughs and sneezes: Use tissue or elbow to cover your mouth and nose. Throw away tissue and wash hands immediately.
- Avoid touching your face: Avoid touching your eyes, mouth, nose.

3. Keep a Healthy Lifestyle

- Balanced diet: Eat fruits, vegetables, and lean protein to support your immune system.
- Regular exercise: Physical activity boosts your immune system.
- Get enough sleep: Sleep supports your immune system.

4. Avoid Close Contact

- Stay away from sick people: Avoid close contact with sick people and if you are sick, keep your distance from others to protect them from getting sick.
- Stay home when sick: Do not go to school, work, or other public places if you have flu symptoms, to prevent spreading the virus.

5. Clean and Disinfect

- Regular cleaning: Clean and disinfect touched objects frequently, like doorknobs, light switches, mobile devices.
- Use disinfectants: household disinfectants can kill germs on surfaces.

6. Consider Antiviral Medication

- Consult your doctor: If you are at high risk for flu complications and talk about antiviral medications. These can help reduce the severity and duration of the flu if taken soon after symptoms begin.

7. Stay Informed

- Monitor Flu Activity: Keep up with local activity in the area through the local health department and Center for Disease Control (CDC).
- Follow Public Health Advice: Keep the recommendations from public health officials.

Behavioral Health Benefits

All MedStar Family Choice members have access to Behavioral Health Benefits which include Mental Health, Substance Use Disorder, and Alcohol Use Disorder treatment. These benefits are managed by the State Public Behavioral Health Vendor Carelon at **800-888-1965**, and billed thru Maryland Medical Assistance/Medicaid, NOT MedStar Family Choice. PCP referral is NOT needed.

Patients can locate a provider that accepts Maryland Medical Assistance/Medicaid by:

- Call Carelon at **800-888-1965** for a listing of provider contacts
- Searching one of the following sites for “Medicaid” or “Medical Assistance” accepting providers, selecting Mental Health, Substance Use services or both.
- [Samhsa.gov/find-help](https://www.samhsa.gov/find-help)
- [Psychologytoday.com/us/psychiatrists](https://www.psychologytoday.com/us/psychiatrists)
- [Psychologytoday.com/us/therapists](https://www.psychologytoday.com/us/therapists)
- [Psychologytoday.com/us/treatment-rehab](https://www.psychologytoday.com/us/treatment-rehab)

Maryland’s Public Behavioral Health vendor is available to assist you with any questions regarding your behavioral health benefits at **800-888-1965**.

If patient is in crisis and unable to wait for scheduled appointment, help is available 24 hours a day, 7 days a week by calling 988.

MedStar Family Choice Social Work Case Managers can be reached at **800-905-1722** option 2 & option 2 to guide members in this process if needed, although we do not manage the benefits.

Understand PCP auto assignment

Members new to MedStar Family Choice who fail to designate a primary care provider (PCP) after enrolling in MedStar Family Choice will be automatically assigned to a PCP that is geographically close to the member's residence. Members under the age of 21 are automatically assigned to EPSDT providers, as appropriate.

Members may change PCPs at any time by calling Member Services. Your individual provider name will not be listed on the member's card. The member's card will show a variation of your practice name. However, please remember, you are permitted to see the member as long as you are participating with MedStar Family Choice and the member is eligible with MedStar Family Choice on the date of service.

When possible, we ask that your office assist the member in updating their card to reflect the correct primary care practice by calling Member Services at **888-404-3549**. PCP's can view or download their member rosters or Provider Panel Reports by accessing the new Provider Portal at mfcmdprovider.healthtrio.com.

Please contact Provider Customer Service at **800-261-3371**, option 1, if you have more questions regarding eligibility. Should you have any questions regarding individual provider participation, please contact Provider Relations at **800-261-3371**.

Pass-through billing is prohibited

MedStar Family Choice and the Maryland Department of Health prohibit pass-through billing. Pass-through billing occurs when the ordering provider requests and bills for a service, but the service is not performed by the ordering provider or those under their direct employment.

Subcontracted individuals/businesses are not considered under "direct employment." You must only bill for services you directly perform if you are a physician or practitioner within a group.

The MedStar Family Choice Provider Agreement, Section 9.4 states that providers/groups "may not enter into subcontracts for performance of its obligations hereunder, without the prior written approval of MedStar Family Choice. To be reimbursed, the rendering provider must be enrolled with Maryland Medicaid (ePREP) and credentialed with MedStar Family Choice, and obtain prior authorization, if required. **(Note in October 2026, Maryland Medicaid provider enrollment will be transitioned from ePREP to MPRIME.)**

Maryland Department of Health has provided the following example in a Provider Transmittal: "Per limitations provided in COMAR 10.09.02.04, providers may only bill Medicaid for services they or their employees have actually performed when billing for a service that includes both a technical and a professional component. Providers may not bill for services they have subcontracted to be performed by a third party."

“For example, Dr. Smith enters into an agreement to pay ABC Consultants directly to interpret ultrasounds that Dr. Smith has performed. The agreement does not establish an employer/employee relationship. In this case, Dr. Smith would bill for the service using a modifier TC to indicate that he only performed the technical component of the service. Even though Dr. Smith has an arrangement where he has paid ABC Consultants to perform the professional component, Dr. Smith may not bill for the professional component because neither he nor his direct employees have performed the service. ABC Consultants would bill the Program for the professional component only using the modifier 26.” Likewise, a provider may not bill for both the professional and technical components when a subcontractor is used to conduct the technical component. Subcontractors should be contracted/credentialed by MedStar Family Choice, be enrolled in Maryland Medicaid, and bill under their own NPI. Please contact Provider Relations at **800-261-3371** if you need additional information.

Let's decrease emergency department utilization as a team

MedStar Family Choice is looking to reduce emergency department (ED) utilization in 2026 for minor illnesses or injuries. As providers, you can have a meaningful impact on accomplishing this goal. When you see a MedStar Family Choice member, please discuss with them that there are other options to being treated for minor illnesses or injuries.

- Encourage the member to contact you or your office first before going to the ED unless it is life threatening.
- If your office provides extended office hours or urgent care services, please educate our members about this available option and explain the benefits of not sitting in the ED.
- Encourage the use of an urgent care facility when appropriate, like MedStar Health Urgent Care, University of Maryland Urgent Care, Patient First, or Express Care. Explain to the member that it's more convenient because of the decreased wait time.
- Promote MedStar eVisit as it gives MedStar Family Choice members 24/7 video access to board-certified doctors at no cost. Members can connect with a medical doctor via secured video from their tablet, smart phone, or computer for non-urgent medical conditions. To learn more or schedule an eVisit, download the MedStar eVisit app or visit [MedStarHealth.org/eVisit](https://www.MedStarHealth.org/eVisit).
- Help us educate our members on the availability of their Nurse Advise Line benefit. Members can contact a nurse with questions or concerns about their minor illness or injury 24/7 by calling the nurse hotline at **855-210-6204**.

Thank you for partnering with us in educating our members on appropriate use of the ED.



How we detect false claims and statements

MedStar Family Choice is committed to complying with federal and state laws and regulations. This is intended to provide you with information on laws pertaining to the prevention and detection of fraud, waste, and abuse, in accordance with the requirements of the Federal Deficit Reduction Act of 2005. This article also describes the procedures in place within MedStar Health and MedStar Family Choice for detecting and preventing fraud, waste, and abuse. The MedStar Office of Corporate Business Integrity (OCBI) provides all MedStar Health facilities with compliance oversight, billing integrity support, occurrence reporting and resolution, and training and education. MedStar's Internal Audit department conducts routine, independent audits of business practices, and all financial managers are required to attend training on the financial manager's code of ethics and reporting obligations.

Associates (employees), physicians, contractors, and patients are encouraged to report privacy, financial reporting, and other compliance concerns by calling the MedStar Integrity Hotline toll-free at **877-811-3411**. The hotline is available 24 hours a day and calls will be confidential. Associates, physicians, practitioners, contractors, members, and patients can also email OCBI at compliance@medstar.net. Any person reporting fraud and abuse may also contact the MedStar Family Choice

Maryland Medicaid Compliance Director at **410-933-2283**. Providers may also call MedStar Family Choice Provider Services at **888-404-3549**. Retaliation for reporting in good faith, an actual or potential violation or problem, or for cooperating in a compliance, legal or other investigation is expressly prohibited by MedStar policy.

If overpayments related to fraudulent or abusive billing have been identified, we will retract these payments made to providers. MCOs are required to notify the Maryland Department of Health Office of the Inspector General – Health (MDH OIG-H) and the Maryland Office of the Attorney General (OAG) Medicaid Fraud and Vulnerable Victims Unit (MFVUU) of identified overpayments. These entities may perform their own investigation. Penalties such as fines, loss of licensure, exclusion from State and federal programs, or imprisonment can occur for providers found guilty of fraudulent activity.

Federal False Claims Act

The Federal False Claims Act, 31 U.S.C. §§ 3729-3733, applies to persons or entities that knowingly and willfully submit, cause to be submitted or conspire to submit a false or fraudulent claim, or that use a false record or statement in support of a claim for payment to a federally funded program.

The phrase “knowingly and willfully” means that the person or entity had actual knowledge of the falsity of the claim or acted with deliberate ignorance or reckless disregard for the truth or falsity of the claim. Persons or entities that violate the Federal False Claims Act are subject to civil monetary penalties (42 U.S.C. § 1320a-7a) and payment of damages due to the federal government. Under the False Claims Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government’s damages plus civil penalties. Each year the fines are adjusted for inflation. As of July 2025, the penalties were updated to \$14,308 to \$28,619 per false claim. The Federal False Claims Act provides that any person with actual knowledge of false claims or statements submitted to the federal government may bring a False Claims Act action in the government’s name against the person or entity that submitted the false claim. This is known as the False Claims Act’s “qui tam” or whistleblower provision. Depending on the outcome of the case, a whistleblower may be entitled to a portion of the judgment or settlement. The Federal False Claims Act provides protection to whistleblowers that are retaliated against by an employer for investigating, filing, or participating in a False Claims Act lawsuit.

State False Claims Acts

Several states have enacted false claims acts in an attempt to prevent the filing of fraudulent claims to state funded programs. Maryland has a similar law, titled the Maryland False Health Claims Act of 2010, originally enacted as Maryland Senate Bill 279. The Maryland law prohibits actions constituting false claims against state health plans or programs, permits whistleblowers to bring actions under the law and provides protection for whistleblowers from retaliation home connections. Penalties and damages may also be assessed.

Understanding the CAHPS member Communications survey

In 2026, the State of Maryland Department of Health (MDH) contracted with the Center for Study of Services (CSS), a National Committee for Quality Assurance (NCQA)-certified survey vendor, to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H Adult Medicaid Survey. The purpose of the survey is to assess members' experience with MedStar Family Choice. MedStar Family Choice members were asked to give their overall ratings of their Doctors, Health Care, and Health Plan along with questions regarding how well doctors communicate, ease of getting care, timeliness of care, and customer service.

"For the composite measure "How Well Doctors Communicate," MedStar Family Choice's adult population survey results revealed a summary rate of 91.19% which is 2.29 percentage points lower than in the survey conducted in 2025.

Contributing survey statements for this measure included:

- My personal doctor explained things.
- My personal doctor listened carefully.
- My personal doctor showed respect.
- My personal doctor spent enough time.

Interpreter Services

MedStar Family Choice is dedicated to ensuring all members, regardless of their language or communication needs, can access the care and services they need. Members with limited English proficiency or hearing/ sight impairments have access to interpreter services (telephonic, in-person, or video) and document translation, which support clear communication and help members fully engage in their healthcare.

To request these services, please follow the steps below:

Telephonic Interpretation Services:

- Providers can direct members to the Outreach Department at **800-905-1722**, option 1, for assistance with appointment scheduling, care coordination, benefit, and plan inquiries, etc.



In-office Interpreter Services:

- If a member requests an in-office interpreter, complete the [Interpreter Request Form](#) and email it to mfc-providerrelations2@medstar.net. It is important to submit the form as early as possible before the appointment to ensure interpreter availability.

Document Translation Services:

- Providers can request document translations by submitting the document and request to mfc-providerrelations2@medstar.net
- Provider's may choose to complete the Interpreter Request Form, attach the requested document with the member's information, and email it to mfc-providerrelations2@medstar.net.

Provider may visit the Interpreter Services page of our website at [MedStarFamilyChoiceMD.com/Maryland-Providers/Provider-Support/Outreach/Interpreter-Services](https://www.MedStarFamilyChoiceMD.com/Maryland-Providers/Provider-Support/Outreach/Interpreter-Services).

Verify member eligibility for Medicaid products

Prior to rendering services, provider offices must verify that MedStar Family Choice Medicaid members have benefits on the date of service. If a member does not have benefits on the date of service, then claims will deny. Along with verifying member benefits, providers should be familiar with MedStar Family Choice products and that their office is contracted as a participating provider. Providers should note which cards members are presenting and verify that they are contracted as a par provider.

- Sample member ID cards for each Medicaid product are available on our website at [MedStarFamilyChoiceMD.com](https://www.MedStarFamilyChoiceMD.com). Please follow these steps to determine eligibility for your MedStar Family Choice— Maryland HealthChoice patients:
- Call the Maryland EVS line at **866-710-1447** to verify if a patient is eligible to receive benefits and is active with MedStar Family Choice on the date of service. More information on the EVS line can be found at [EMDHealthChoice.org](https://www.EMDHealthChoice.org).
- If providers have further questions regarding member benefits under MedStar Family Choice, please contact the MedStar Family Choice Provider Services Call Center at **800-261-3371**.

*QUICK TIP: To easily identify the correct MedStar Family Choice product, member ID numbers start with nine for Maryland HealthChoice.

Did you know we offer the “Growing Together Prenatal Program” Program?

MedStar Family Choice offers the Growing Together Prenatal Program for eligible members who are expecting. By enrolling in the Growing Together program, members will be eligible to receive gift cards for keeping their OB appointments. Members can earn gift cards by attending OB classes and seeing the dentist during their pregnancy. MedStar Family Choice members can also take online prenatal classes located on [MedStarFamilyChoiceHealthyLife.com](https://www.MedStarFamilyChoiceHealthyLife.com). Members or providers can call **443-692-1012** for more information.



When to schedule postpartum visits

As part of the MedStar Family Choice Growing Together Postpartum Program, postpartum coordinators outreach members within 1 to 2 days after delivery to provide education and encourage the new mothers to schedule a comprehensive postpartum care exam as soon as possible. MedStar Family Choice postpartum coordinators will schedule this appointment for the member and transportation assistance is available if needed.

Ideally, the comprehensive postpartum care visit should occur between 21 and 56 days after delivery. Members who complete their comprehensive postpartum exam within this timeframe may be eligible for a prepaid incentive.

Additionally, MedStar Family Choice offers telehealth postpartum visit with a nurse practitioner, only if the member did not receive prenatal care or cannot get into their OB office within the ideal timeframe.

Please note: If a member sees their provider for a two-week wound check or blood pressure check, they must still be seen for a separate comprehensive postpartum visit.

Members can contact our Growing Together Postpartum Coordinator, Jeanne Cox at **443-692-1026** to inquire about the program and schedule transportation.

Providers that are excluded from payments

The U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) and state government agencies have the authority to exclude individuals and entities from government funded health care programs. Those that are excluded may not receive payment from government agencies and their subcontractors, including MedStar Family Choice. The payment ban applies to any products and services furnished, ordered, or prescribed.

Providers are required to screen all employees and contractors for exclusion prior to hire and monthly thereafter. Payments may be retracted if reimbursement is directly or indirectly related to the excluded parties for items and services received by a Medicaid recipient. The OIG maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals/Entities (LEIE). A searchable list can be found on the HHS OIG website at [Exclusions.oig.HHS.gov/](https://exclusions.oig.hhs.gov/). The Maryland Department of Health also maintains a list of Maryland Medicaid sanctioned providers and entities excluded from participation in the Medicaid program which can be found at Maryland.gov/MMCP/Provider/Pages/Sanctioned_List.aspx.

These and other lists must be checked regularly. Questions and concerns regarding sanctions and exclusions can be directed to the MedStar Family Choice Compliance Director at **410-933-2283**.

How provider performance data is used by MFC

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

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

Please contact Provider Relations at mfc-providerrelations2@medstar.net or **800-261-3371, option 5**, with any questions and or concerns.



Important Reminder Regarding Laboratory Services

MedStar Family Choice wants to ensure our provider network knew where to send members for laboratory services that cannot be performed in-office. Here is a list of our current in-network laboratory service providers:

- Accupath Diagnostic Laboratories
- Dianon System
- Esoterix Genetics Laboratories
- Exact Sciences Laboratories
- Laboratory Corporation of America
- Litholink Corporation
- Medtox Laboratories Inc
- Monogram BioScience Inc
- Myriad Genetic Laboratories Inc
- Sequenom Laboratories

As a participating provider for MedStar Family Choice, please be sure to use our in-network laboratories. If the laboratory is not listed in the above table, they are not participating and remain out-of-network for MedStar Family Choice.

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.

Members directed to a laboratory service center must be sent with a laboratory requisition form or a referral and must include specific member information; type of laboratory test being ordered along with the associated diagnosis code(s).

Please be sure to verify member eligibility and prior authorization requirements for laboratory services provided to members. All laboratory services provided by an out-of-network laboratory require prior authorization.

When and how to seek prior authorization

Not all services or medications require prior authorization! MedStar Family Choice wants to make it easy for you to know **when and how** to seek prior authorization if required. To learn more visit [MedStarFamilyChoiceMD.com/Maryland-Providers/Utilization-Management](https://www.MedStarFamilyChoiceMD.com/Maryland-Providers/Utilization-Management)

Non-Pharmacy Requests	Pharmacy Requests
Under the Preauthorization and Utilization Management tile, click on View Preauthorization and Utilization Management.	Under the Pharmacy and Formulary tile, click on View Prescription Information.
You will now see Forms and Additional Information.	You are now on the Pharmacy and Prescription Information page. Click on MedStar Family Choice Formulary to see if your desired medication requires prior authorization (PA).
Click on List of services that require pre-authorization to see the services that require a pre-authorization.	If the medication needs a PA, click on Prior Authorization Table and Step Therapy on the Pharmacy and Prescription Information page to see the PA criteria for your medication.
On the Forms and Additional Information page, select and complete the form that applies to your needed service.	If you need a PA form: go to the Pharmacy and Prescription Information page and scroll down to Prior Authorization forms.
- Several forms may be completed in the web browser then printed or downloaded to your computer and completed. They are the: – Prior authorization (non-pharmacy) request form. – DME authorization form. – Prior authorization-home health services request form.	- Which form to pick: – For medications that require a PA or that are Non-Formulary, pick General Medication Prior Authorization Form. – For Opioids, use the Opioid Prior Authorization Form. – For Hepatitis C medications, use the Hepatitis C Prior Authorization Form.

PRO TIPS

DON'T MAKE THE MISTAKE OF LEAVING OUT INFORMATION! Complete each line fully.

- Provide a contact person's name and phone—preferably the person to whom any questions should be directed. **Please provide a DIRECT or BACK LINE number.**
- If a procedure is being done in a hospital or ambulatory surgery center, provide the facility name and NPI number.
- ICD-10 codes and CPT or HCPCS codes are required, along with number of units or visits being requested.
- If the request is for a medication, indicate its name, dose, and frequency. If it is for a non-formulary medication, **you must indicate what formulary options have been tried and failed.**
- If something is being requested out-of-network, either document on the form or supply a letter of medical necessity to justify the reasoning behind the out-of-network request.
- **Attach all clinical notes/medical records**, pertinent radiology studies, and lab results to support the request for service. **The PA form does not substitute for clinical notes.**

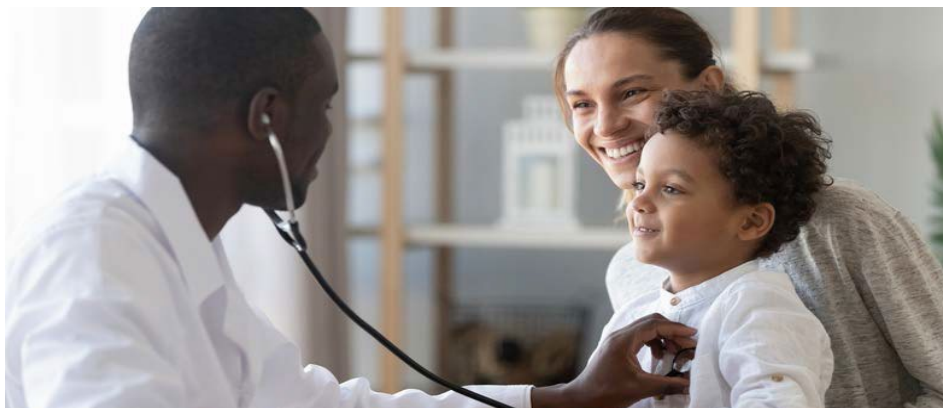
Once the form is complete, combine it with supporting medical records, radiology or lab studies and **fax it to 410-933-2274**. One of our experienced clinical staff will review the request and make a medical necessity determination.

If you follow this process and send all the required information, we will process your request for authorization within two business days of receipt for non-pharmacy authorizations, and within twenty-four (24) hours for outpatient pharmacy authorizations.

Keep pediatric patients healthy with EPSDT screenings and labs

Maryland Healthy Kids/EPSDT certified providers must adhere to the standards of preventative health care described in the Maryland Healthy Kids Program Manual. This includes following the Maryland Healthy Kids Preventative Health Schedule. The schedule reflects minimum standards required for all Maryland Medicaid recipients from birth to 21 years of age.

The current schedule is available [here](#). Information on Maryland Healthy Kids/EPSDT Screening Components including validated tools can be found here. Coding and Billing Guidelines for Assessments and Screenings can be found here. Please contact the Division of Healthy Kids program at **410-767-1836** with any questions. Visit Health.Maryland.gov/MMCP/EPSDT for more information.



Maryland EPSDT (Healthy Kids)

The state of Maryland **requires** all managed care organizations (MCO's), such as, Medstar Family Choice, to adhere to and undergo an annual audit of the Maryland Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/ Healthy Kids standards. Here is a checklist to assist you with the state EPSDT requirements and audit.

EPSDT Laboratory Screening Tests

- 2 metabolic screenings (PKU) – first test completed 24 hours after birth.
- Lead and anemia screenings at ages 12 and 24 months.
- Dyslipidemia screening once between ages 9-11 years, 18-20 years.
- HIV testing – 1 test between 15 and 18 years.

EPSDT Risk Assessments

- Maternal depression screening when the child is 1 month, 2 months 4 months, and 6 months of age.
- Tuberculosis risk assessment at 1 month, 6 months, 12 month and then annually.
- Lead risk assessment at 6 months and at every well visit until age 6 years.
- Autism screening required at the 18-month and 24-30-month visits.
- Heart disease risk assessment at 2 years and annually.
- Mental Health & Depression screenings begin at 4 years (or younger if indicated) and then annually.
- Anemia risk assessment at age 11 years and then annually.
- STI/HIV risk assessment at age 11 years and then annually.
- Substance abuse screening begins at age 11 years (or younger, if indicated) and then annually.

We're here to help

For more information about EPSDT requirements, go to mmcp.health.maryland.gov > EPSDT



Reminders

- Update immunizations, screenings, and assessments in the medical record
- Vaccine history is updated and completed
- A documented referral to a dentist should begin at age 1 and annually
- Enroll in the Vaccines for Children (VFC) program and the Maryland immunization registry (ImmuNet) to update the child's immunization history
- DOCUMENT all refusals of immunizations & care



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If you have questions regarding information in this newsletter, or if you would like to submit an article for our next issue, please contact us at **mfc-providerrelations2@medstar.net**.

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