

Maryland Primary Adult Care Provider Manual

January 2012

Introduction to the PAC Provider Manual

The Primary Adult Care Program or PAC is a health care program for low-income Maryland residents. The Maryland Department of Health and Mental Hygiene (DHMH) which administers PAC, combined two of its programs - the Maryland Pharmacy Assistance Program and the Maryland Primary Care Program. The PAC Program covers individuals 19 or older who are not eligible for Medicare or full

Medicaid benefits. In addition to prescription drug coverage, the PAC Program provides primary care benefits and coverage for mental health services.

Much like HealthChoice, DHMH has contracted with managed care organizations (MCOs) to provide primary care and pharmacy benefits to PAC enrollees. PAC enrollees must choose an MCO or they will be assigned to one. The State will pay the MCO a capitated rate. MCOs then contract with primary care providers. MCOs are required to provide some additional services for individuals who have diabetes. Otherwise the PAC program does not include specialty care, inpatient and outpatient hospital services. (Read Page 41 for a list of non-covered services.)

The purpose of this manual is to highlight and explain the elements of the PAC program. Where possible, PAC program operations will mirror those of the HealthChoice Program. Like in HealthChoice, each MCO has policies and procedures that providers must adhere to. Any questions a provider has about the specific policies of Maryland Physicians Care which are not addressed in this Manual must be directed to Maryland Physicians Care Provider Relations at **1-800-953-8854, option 2, option 3.**

This PAC provider Manual is divided into seven sections as described below:

Section I. General Information- Key Facts For Providers

This section provides general descriptive information on Primary Adult Care (PAC) Program including, but not limited to, program eligibility, and general information on MCO credentialing and reimbursement policies.

Section II. Provider Responsibilities

This section discusses expectations of all providers, regardless of MCO affiliation.

Section III. PAC Benefits and Services

This section provides a listing of the PAC benefits. This includes benefits that are the responsibility of MCO. *If the MCO has chosen to offer its enrollees optional benefits, those benefits will be listed in this section as well.* This section also identifies benefit limitations and services that are not the responsibility of the MCO and services which are not covered under the PAC Program.

Section IV. Specialty Mental Health Services

This section describes the mental health services that PAC enrollees can receive from the Public Mental Health System.

Section V. Enrollee Information

This section addresses enrollee rights and responsibilities, the MCO Complaint Process, and procedures for enrollees to select and change PCPs.

Section VI. DHMH Quality Improvement Program

This section reviews DHMH's quality improvement activities and the DHMH Complaint Process.

Section VII. Forms and Attachments

This section contains forms and other reference materials that may be useful to a provider participating in the PAC program.

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Section I

General Information Maryland Primary Adult Care Program

The Maryland Primary Adult Care Program (PAC)

The PAC Program serves very low-income individuals who are not eligible for Medicare or full Medicaid benefits. When the program began on July 1, 2006, individuals who had previously been in the Pharmacy Assistance Program were enrolled in the PAC Program. PAC has additional coverage for primary care and mental health services. Individuals who are eligible for PAC must enroll in one of the participating MCOs to keep their prescription drug coverage and to get the additional primary care services.

PAC Eligibility

The eligibility for PAC is based on income. For eligibility related questions, call 1-800-226-2142. Recipients must re-apply for PAC annually.

Provider Credentialing and Role of the PCP

Provider Credentialing

Credentialing is an integral component of the health plan's quality management program. Based on approved standards, the process is completed before a health care professional may provide care or service to a health plan member.

Health care professionals who are subject to credentials review and verification prior to acceptance as a MPC network participant may include, but are not limited to, the following:

- Medical doctor (MD)
- Certified nurse practitioner (CNP)
- Non-physician practitioners who have an independent relationship with the plan (i.e., to whom the plan can direct members and whom members can select as PCPs)

Application and Attestation

The health care professional must submit a completed application signed within 180 calendar days for MPC PAC prior to the Credentialing Committee's decision that includes a current signed attestation regarding the following:

- Reason(s) for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and/or felony convictions
- History of loss or limitation of privileges or disciplinary activity
- Correctness and completeness of the application
- Current malpractice insurance as required by contract

Verification of Malpractice, Sanction Activity or Convictions

The health plan queries applicable sources for the following information prior to the credentialing decision and includes the information in the health care professional's credentialing file for MPC within 180 calendar days:

- Information about sanctions or limitations on licensure as applicable
- Information about Medicare and Medicaid sanctions activity
- Information about felony convictions as reported on applicable registries

Sources may include the National Practitioners Data Bank (NPDB), Healthcare Integrity and Protection Data Bank (HPDB), the Federation of State Medical Boards [FSMB], the Office of the Inspector General (OIG), state agencies or other NCQA-approved data banks or reports.

Initial Site Visit

The health plan conducts an initial site visit of primary health care professionals, primary care obstetricians, and high-volume behavioral health providers to ensure that the health care professionals' offices and medical record keeping practices meet the health plan's standards.

Health care Professional's Access to Credentialing Information

MPC maintains a fair credentialing process by affording health care professionals the right to review information submitted in support of their credentialing application. The health plan is obligated to inform a health care professional if credentialing information gathered by the plan varies substantially from information the health care professional provided and must allow the health care professional to correct erroneous information submitted by another party. The health plan must ensure that credentialing information is kept confidential.

Ongoing Monitoring

On an ongoing basis, the health plan regularly monitors applicable sources to determine whether reports on the following identify network health care professionals:

- Information about sanctions or limitations on licensure
- Information about Medicare or Medicaid sanctions activity

If a network health care professional is identified in such a report, the plan is responsible for obtaining and reviewing pertinent information, storing it in the health care professional's credentialing file, and, if applicable, initiating appropriate follow-up action, which may include a re-credentialing review prior to the 36 month re-credentialing cycle.

The health plan also regularly monitors the following internal information:

- Grievances
- Quality data/issues/activities

The health plan has defined certain quality and patient safety issues that must be submitted to the Credentialing Committee for review. Whenever such an issue is identified, Quality Management will submit the issue to the committee at the time of the occurrence, whether or not the health care professional's credentials are due to expire.

Role of the PCP

- PCP shall verify the enrollment and assignment of the member via MPC roster prior to the provision of Covered Services. Failure to verify Member enrollment and assignment may result in claim denial.
- PCP shall provide or arrange for medically covered services to members as defined herein, on a twenty-four (24) hour per day basis, seven (7) days per week.
- PCP agrees to ensure that a Member's waiting time at the PCP's office shall not exceed sixty (60) minutes, unless the PCP is unavailable due to an emergency.
- PCP shall provide to members (a) office visits during regular office hours which shall not be less than twenty (20) hours per week and not less than three days per week for individual practitioners; or not less than thirty-five (35) hours per week for group practices, and (b) office visits, home visits or other appropriate visits during non-office hours as determined medically necessary and shall answer phone calls within a reasonable time, during normal business hours, and have available on-call response, within a reasonable time, twenty-four (24) hours a day.
- PCP shall coordinate the provision of covered services to members by: (a) counseling members and their families regarding Member's medical care needs including family planning and advance directives; and (b) initiating referrals of Members for specific Covered Services to Participating Health Professionals, and DHMH Specialty Mental Health System.
- PCP shall maintain a current DEA and CDS number throughout the term of this Agreement and MPC encourages PCP to record DEA and CDS number on all prescriptions.
- PCP shall be State licensed and have training and experience in his/her respective fields(s) of practice, may be Board Certified, have completed an approved training program or be generally recognized by the providers community as being skilled in his/her respective practice.
- PCP shall provide preventive health services in accordance with DHMH PAC Rules and Regulations and MCO medical policies.
- PCP shall prescribe and authorize the substitution of generic pharmaceuticals and agrees to abide with MPC Drug Formulary.
- PCP agrees to render services to Members who are diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC) in the same manner and to the same extent as other Members and under the compensation terms set forth herein.
- PCP agrees to adhere to MPC managed care philosophy and principles and to participate as active members on MCO standing committees.
- PCP agrees to utilize current CPT Coding guidelines including HCPCS.
- PCP shall comply with Federal Regulations of the Occupational Safety and Health Administration including, without limitation, the regulations concerning Blood borne Pathogens Standards at 29 C.F.R. Part 1910.1030, which became effective January 1, 1992. PCP shall comply with the Patient Self-Determination Act (effective December 1, 1991.)

- PCP shall abide by and follow MPC's medical record standards outlined in Attachment I-B.

Provider Reimbursement

Maryland Physicians Care Provider Reimbursement

Payment to individual providers is in accordance with their contracts with Maryland Physicians Care or with management group that contracts on behalf of its providers with Maryland Physicians Care. Payment for services provided under an individual provider's contract may or may not be on a capitated basis. The amount and nature of the risk assumed by an individual provider or by a management group contracting on behalf of its providers with Maryland Physicians Care will be entirely a function of the specific terms of the individual contract with Maryland Physicians Care.

Eligibility Verification System

Prior to rendering services, call (*insert MCO eligibility phone number when available or*) the Medicaid Eligibility Verification System (EVS) at 1-866-710-1447 to check the enrollee's eligibility and their MCO enrollment status. You must bill the MCO indicated in the EVS message. A PAC enrollee must be enrolled in Maryland Physicians Care on the date of service in order for Maryland Physicians Care to pay for primary care services. Primary care services are only covered when a PAC enrollee is active in an MCO. However, when an individual is eligible for PAC but is not actively enrolled in an MCO, their pharmacy and mental health services will be covered by the PAC (yellow and white) ID card.

Third Party Liability

PAC enrollees may have other third party coverage. Though this should rarely occur, the EVS message will indicate that the individual has other insurance coverage. Like Medicaid fee-for-service, Maryland Physicians Care requires that providers bill the other insurance first (*or MCO insert your instructions*).

Timely Payment

In accordance with the Maryland Annotated Code, Health General Article §15-1005, Maryland Physicians Care will mail or transmit payment to a provider eligible for reimbursement for covered services within 30 days after receipt of a clean claim. If additional information is necessary, Maryland Physicians Care will pay a provider for covered services within 30 days after receipt of all reasonable and necessary documentation. Maryland Physicians Care will pay interest on the amount of the clean claim that remains unpaid 30 days after the claim is filed.

PAC does not cover services (except for some emergency room services) delivered in hospitals, including outpatient and inpatient services. However, should Maryland Physicians Care contract with a provider site that is usually paid Health Services Cost Review Commission (HSCRC) rates, Maryland Physicians Care must pay the applicable rate.

Reimbursement of Out of Plan Providers for Self-Referred Family Planning Services

MCOs must reimburse out-of-plan providers for all family planning services except sterilizations. PAC does not cover sterilizations. Read section III-Benefits for more information on Family Planning services covered under PAC. If you have questions, call the Medicaid Family Planning Program at 800-456-8900.

Reimbursement of Providers for Services Under Appeal

If Maryland Physicians Care reduces, or terminates a covered service, PAC enrollees have an appeal right. Pending the outcome of an appeal, if the enrollee requests ongoing services within 10 days of the denial, Maryland Physicians Care must reimburse providers for the services. PAC enrollees do not have appeal rights for non-covered services.

Provider/PCP Contract Termination

If a PCP's contract with Maryland Physicians Care is terminated for one of the following:

- For reasons other than the quality of care or the PCP's failure to comply with contractual requirements related to quality assurance activities; or
- The MCO's reduction of PCP's reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to the MCO by the Department, and the MCO and PCP's inability to negotiate a mutually acceptable rate.

The PAC enrollees assigned to the PCP may elect to change to another MCO in which the provider participates by calling the Enrollment Broker at 866-676-5880 within 90 days of the provider contract termination.

Continuity of Care

Maryland Physicians Care is responsible for providing on-going services, to the extent that the services are within the scope of the benefit package, until Maryland Physicians Care completes an initial evaluation of the enrollee and develops a new plan of care. This provision does not apply to any non-covered services the enrollee is receiving at the time of enrollment in Maryland Physicians Care.

If Maryland Physicians Care determines that a reduction in a covered service is warranted, Maryland Physicians Care must notify the enrollee of this change at least 10 days before it is implemented. This notification must inform the enrollee that he/she has the right to formally appeal to the Department by calling the Enrollee Help Line at 1-888-754-0095. In addition, the notice must explain that if the enrollee files the appeal within ten days of the Maryland Physicians Care notification, then Maryland Physicians Care must continue to provide the ongoing **covered service** until the Department decides whether this change is appropriate. Providers involved will also receive a copy of this notification.

Specialty Referrals

Specialty care is not a covered benefit under PAC. When the PCP determines that a service is medically necessary but the service is not a covered PAC benefit, the PCP must take the following steps:

- Refer the enrollee to an appropriate provider of the service;
- Indicate to the specialty provider that the enrollee does not have medical coverage for the referred services; and
- Clearly inform the enrollee that the service is not covered by PAC and that the enrollee will be financially responsible for the services; or
- Provide the enrollee with a completed Statement of Needed Service Form (See form on next page)

To the extent possible, PCPs should refer to specialty providers who can offer a sliding fee arrangement for the non-covered service. While Maryland Physicians Care is not required to arrange or coordinate specialty care, Maryland Physicians Care may assist PAC enrollees in locating a specialist. If the enrollee needs additional help in locating a specialty provider, the enrollee can also call the State's Enrollee Help Line at 1-888-754-0095. Staff will attempt to identify a resource (e.g., FQHC, hospital) for the enrollee.



Attachment I – A

Statement of Needed Service Form

Maryland Primary Adult Care (PAC) Program

Statement of Needed Service Form

-You may use this form when referring a PAC member for specialty care-
*PAC members have pharmacy, outpatient mental health and primary care coverage only.
PAC benefits do not include specialty care.*

Date of Referral:	
1. Patient Information	
Name (Last, First, MI):	
Date of Birth (MM/DD/YY):	MA ID#:
MCO:	
2. Primary Care Provider	
Name (Last, First, MI):	
Institution/Group Name:	
Address (Street, City, State, Zip):	
Phone Number: ()	
3. Specialty/Facility Provider	
Name (Last, First, MI):	Specialty:
Institution/Group Name:	
Address (Street, City State, Zip):	
Phone Number: ()	Fax Number: ()
4. Referral Information:	
Reason for Referral:	
Brief History, Diagnosis and Test Results:	
Patient Responsibility Acknowledgement:	
I understand that the services on this Statement of Needed Service Form are not covered by the PAC Program and that I will be responsible for payment of all charges for the referred service(s).	
Patient Signature: _____	Date: _____



Attachment I–B

**Medical Record Standards for Primary
Care Providers**

Medical Record Standards for Primary Care Providers

The following standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI) as the minimum acceptable standards within MPC provider network.

- **Organization** -- Medical records must be organized in a consistent and uniform filing format. Papers must be firmly attached. Individual unit medical records are required as opposed to family medical records
- **Confidentiality** -- Records are kept confidential in accordance with HIPPA requirements
- **Patient Identification** -- Each page in the medical record must contain patient name or patient identification number
- **Personal/Biographical Data** -- Personal/Biographical data must be noted. This includes address, employer, date of birth, sex, marital status, emergency contacts, home and work telephone numbers
- **Provider Identification** -- All entries, including dictation, must be identified by the author and authenticated by his or her entry. Authentication may include signatures or initials thereby verifying that the report is complete and accurate
- **Entry Date** -- All entries must be dated
- **Legible** -- The medical record must be legible to someone other than the writer
- **Problem List** -- Significant and/or chronic illnesses and medical conditions should be indicated on the problem list
- **Medications** -- Current medications are documented and include drug name, dosage, rate and frequency of medication. When medication remains unchanged, the record includes documentation of at least annual review
- **Allergies** -- The member's allergy status must be readily identifiable. The allergen or No Known Allergies (NKA) must be documented in a uniform, central location on the medical record
- **Past Medical History** -- Past medical history should be easily identifiable and include serious accidents, operations, illnesses and familial/hereditary disease. For Pediatric patients, birth history must be documented
- **Personal Habits (for patients seen three or more times)** -- Notation concerning use of tobacco products, sexual behavior, and history of alcohol and substance abuse for patients age 12 and older
- **Physical Exam (Complete)** -- All body systems to be reviewed within two years of first clinical encounter
- HEENT Lungs Neck Heart NeuroBack and Extremities
- **Height, Weight, Blood Pressure and Temperature** -- Must be documented, as applicable, at the initial health assessment and subsequent visits as indicated

- ***History and Physical*** -- Subjective and objective information is obtained and noted for the presenting complaints
- ***Working Diagnosis*** -- Working diagnosis is consistent with findings (provider's medical impression)
- ***Plan/Treatment*** -- Documentation of the recommended treatment plan that is consistent with the diagnoses
- ***Continuity of Care*** -- Unresolved problems from the previous visit are addressed in the subsequent visit
- ***Patient Education/Instructions*** -- Documentation includes patient instruction regarding significant findings, changes in treatment plan and medications
- ***Consults / Referrals*** -- Reasons for referrals are documented in the medical record. Reports for referrals to specialists are initialed and filed in the medical record within 90 days of the date of the request
- ***Laboratory/Imaging Reports/X-rays and Other Diagnostic Reports*** -- Tests ordered by provider are filed in the medical record and there is evidence that the ordering provider has reviewed the report (i.e., reports are initialed by the ordering provider). Also, there is documentation of the follow-up plan or evidence of appropriate follow-up for abnormal findings
- ***ER Reports / Discharge Summaries*** -- Reasons for ER visits and hospitalizations must be present in the medical record. Discharge Summaries / ER Reports must be present in the medical record and initialed within 60 days of the discharge
- ***Follow-up/Return Visits*** -- Encounter forms or notes specify the follow-up interval. Health maintenance needs are addressed in follow-up. Specific time to return is noted in weeks, months or as necessary
- ***Medical Care/Services/Consults*** -- A general overview of the medical care/services and consults ordered will be reviewed. If any potential quality issues are identified, the reviewer will refer to MPC's designated Medical Director for further direction
- ***Immunization Record*** --
 - For all adult members age 21 and older, records must indicate patient's immunization status for Td
 - For members age 65 and older, record must indicate immunization status for influenza and pneumococcal
 - For all members age 21 and over and at high risk* (See Adult Immunization Guidelines), record must indicate immunization status for influenza, pneumococcal and/or hepatitis B
 - For members under age 21, there must be a complete immunization record documented. If there is no record, a notation regarding immunization status by history should be documented (i.e., UTD per member). Attempts to obtain records must be documented and followed up. Re-immunization must be considered for all school age children without vaccine records of at least one of each vaccine
- ***Preventive Services (for adult members seen three or more times)*** -- Record should indicate preventive services are offered according to MPC's Adult Screening Guidelines for Asymptomatic Men and Women

For Maryland Managed Medicaid Program members under age 21, preventive health services must be provided according to the MPC Pediatric Preventive Guidelines, which are the same as the Healthy Kids (EPSDT Schedule)

- **Advance Directives (for members age 21 and older only)** -- There should be evidence that the member has been asked if they have an Advance Directive (written instructions such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated). Yes/No response should be documented. If response is “Yes”, it is recommended that a copy be requested for the medical record
- **MPC Required Forms** -- MPC and/or State required forms are completed and used appropriately. This includes, but is not limited to, EPSDT Documentation Forms, EPSDT Patient Education Sheets, MA Sterilization Consent Forms, Prenatal Risk Assessment Forms, etc.
- **Outreach / Non-compliance** -- There is documentation of compliance / non-compliance with the medical care plan. Missed appointments are documented in the medical record. Outreach is appropriate and documented in the medical record
- **Alcohol/Substance Screening** -- On the **initial visit**, the member must be screened for alcohol and substance abuse as part of the initial health assessment. The Michigan Alcohol Screening Test (MAST), CAGE or comparable tool can be used for screening purposes

Medical record documentation is required to record pertinent facts, findings, and observations about an individual’s health history, including past and present illnesses, examinations, tests, treatments and outcomes.

The medical record documents the care of the patient chronologically and is an important element contributing to effective high quality care of the member.

The medical record facilitates:

- Accurate and timely claims review and payment.
- The ability of the physician and other health care professionals to evaluate and plan the patient’s immediate treatment, and to monitor a member’s healthcare over time.
- Communication and continuity of care among physicians and other healthcare professionals.
- Appropriate utilization review and quality of care evaluation.
- Collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the hassles associated with claims processing and should serve as a legal document to verify the care provided, if necessary.

The CPT and ICD-9 codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record. Documentation must match or support the level of service reported. This information is not subjective with various payers. It is either correct or it is not. The solution to ensure compliance with coding guidelines is to document and bill for exactly what services are rendered and why these services were performed in the medical records.

Section II
Provider Responsibilities

Appointment Scheduling and Outreach Requirements

Prior to seeing a PAC enrollee, providers must call (*insert State EVS # 1-866-710-1447 or MCO information*) to verify recipient eligibility and MCO enrollment. This step is essential to assure payment for services rendered.

Initial Health Appointment for PAC Enrollees

In general, PAC enrollees must be scheduled for an initial health appointment to occur within 90 days of enrollment. However, there are the following exceptions:

- The provider may determine that no immediate initial appointment is necessary if the enrollee already has an established relationship with the provider.
- As part of the enrollment process the State completes a Health Risk Assessment form to determine if the enrollee has any conditions which require early care. If a need is identified through this process, an initial appointment may be required in less than 90 days. The time frame for the appointment must be consistent with the identified need.

During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of a complete age and gender appropriate physical exam. Read Appendix D for the Schedule of Preventive Screenings. Providers are encouraged to follow the Maryland Healthy Kids/EPSTD Program Periodicity Schedule. Read Appendix C when providing preventive care to PAC enrollees who are 19 or 20 year olds. The State received approval from CMS to waive federal EPSTD requirements for the PAC Program. Therefore, PAC enrollees who are under 21 years of age are not entitled to the full scope of services which is usually required under federal EPSTD rules. Also, providers cannot use vaccines provided by the Vaccines For Children Program (VFC) because VFC vaccines can only be used for children up to age 19.

Individuals with HIV/AIDS

PAC does not cover specialty care. Specialty HIV/AIDS services, including diagnostic evaluation services (DES), viral load testing, genotypic, phenotypic or other HIV/AIDS drug resistance testing, and HIV/AIDS case management services can be accessed through sites that receive federal and state Ryan White grant funds. HIV/AIDS drugs will be covered by the enrollee's PAC (yellow and white) ID card. Maryland Physicians Care is not responsible for HIV/AIDS specialty care, HIV/AIDS drugs, HIV/AIDS drug resistance testing, or HIV/AIDS case management services. If assistance is needed to access resources for individuals with HIV/AIDS, call the AIDS Hotline at 1-800-638-6252.

Individuals with Disabilities

Maryland Physicians Care is responsible for accommodating physical access to covered services and for accommodating enrollees who do not speak English or are hearing impaired enrollees who require and request a qualified interpreter. *(The MCO can delegate the financial risk and responsibility to its providers, but is ultimately responsible for ensuring that its enrollees have access to these services. The MCO must clearly indicate to their providers how this provision is to be implemented.)*

Maryland Physicians Care triage, enrollee services, and case management staff have received training on the special communications requirements of individuals with physical disabilities. Maryland Physicians Care has had its informational materials approved by persons with experience in the needs of individuals with disabilities to assure that the information is presented in a manner that enrollees can understand, whether on paper or by voice translation.

Unlike Health Choice, PAC does not require Maryland Physicians Care to provide case management services. Local health departments are not required to accept referrals for care coordination for PAC enrollees. However, PCPs may contact the local agencies, such as the Health Departments or Office on Aging, as they may be able to provide some limited supportive services to enrollees on a case-by-case basis.

Individuals in Need of Substance Abuse Treatment

The PCP is responsible for performing a substance abuse screen as part of the enrollee's initial health appraisal and periodically as needed and for referring enrollees for substance abuse treatment when it is indicated. The PCP should inform enrollees that the following services are covered: Evaluation, Family Group and Individual Counseling, Methadone Treatment and Community Based Intensive Outpatient Treatment. Inpatient treatment services provided at hospitals **are not** covered. For assistance in locating local treatment programs, call the State's Alcohol and Drug Abuse Administration Referral Line at 410-402-8600.

Pregnancy Related Services

PAC does not cover abortion, prenatal care or pregnancy-related services. Low-income women who are pregnant qualify for full Medicaid benefits under the Maryland Children's Health Program (MCHP). Providers should refer PAC enrollees who become pregnant to the Local Health Department MCHP Eligibility Unit or the MCHP Information Line at 1-800-456-8900. Once an enrollee has MCHP coverage she will be enrolled in a HealthChoice MCO. If the PCP participates in both PAC and HealthChoice, the enrollee will not need to change her PCP or MCO.

MCO Support Services:

Claims Administration

Providers are required to submit all encounters timely to MPC and upon request supply any and all medical records to support submitted encounters. Providers must code to the required level of specificity and encounters must be submitted on a clean claim. All services provided to members are required to be submitted as encounters, regardless of whether the services are covered under a capitated or per diem payment arrangement.

Timely Filing Limitations

Providers are required to submit electronic or paper claims to MPC for reimbursement within one hundred eighty (180) days from the date of service. For a claim on a CMS 1500 or UB-04 claim form, one hundred eighty (180) days is counted from the day that the service was performed. Claims that are not initially received within one hundred eighty (180) days of the date of service may be denied for payment. Please mail medical claims to:

Maryland Physicians Care MCO Claims
P.O. Box 61778
Phoenix, AZ 85082-1778

MPC prefers to receive electronic claims via a MPC-approved Electronic Data Interchange (EDI) vendor. Please contact your Provider Relations Representative for further information on electronic claims or for a list of approved EDI vendors.

After MPC has adjudicated a claim, you will receive a Remittance Advice with the reimbursement, which will provide details about the submitted claim and its status.

Claim Inquiries

Providers may contact MPC's Claims Inquiry/Claims Research Department (CI/CR), to check the status of claims submitted for reimbursement, clarify any denials or other claim processing actions. CI/CR can be reached at 1-800-953-8854, Option 2, then Option 2. Registered network providers may also perform claims inquiry through the employment of MPC's HIPAA-compliant web portal, <https://MarylandPhysiciansCare.abovehealth.com/>

Acceptable Claim Forms

All claims for professional services must be submitted on a CMS 1500 claim form. Claims for eligible services rendered in the emergency department of a hospital must be submitted on the UB-04 claim form. Claims submitted on any other claim form will be returned to the provider.

Acceptable Claim Attachments

MPC requires the following documents to be attached to a CMS 1500 or UB-04 claim form when submitted for reimbursement:

- Explanation of Benefits statement when a MCO member is covered by another payer
- A Medicare remittance notice, when the claim for the MCO member involves Medicare as a primary payer
- History/Physical and office notes when a procedure or service has no corresponding CPT or HCPCS code

Provider Identification Number

All providers submitting claims to MPC must indicate their Federal Tax Identification number and medical assistance number. The Federal Tax Identification number must match the ID number on the Participating Health Provider Agreement with MPC. Claims submitted without the correct Federal Tax Identification number will be denied. **Claims must also include NPI number for all providers referenced on the claim form.**

Claims Adjudication

MPC evaluates all claims and payments for covered services in light of claim information on the condition treated and services or items provided and AMA CPT-4 guidelines, national bundling edits including the Correct Coding Initiative, modifier usage, global surgery rules, multiple procedure reductions, unit limitations, age/gender appropriateness and other reimbursement or utilization criteria, and reimburse or adjust reimbursement for covered services in accordance with the information and guidelines and criteria.

MPC adjudicates all clean claims in accordance with the Uniform Claims Forms (COMAR 31.10.11) regulations.

Claims Resubmission

A provider may resubmit missing, corrected or requested information for a previously submitted claim within ninety (90) working days from the date of denial to:

Maryland Physicians Care MCO Claims

Attn: Claims Resubmission

P.O. Box 61778

Phoenix, AZ 85082-1778

Please indicate “Claim Resubmission” on the claim form.

MCO Provider Complaint Process

MCO Provider Complaint Process Maryland Physicians Care has an established process for registering and responding to provider complaints in a timely fashion, including standards for timeliness that recognize the need for expedited determinations in situations defined as emergent, urgent, or expedited. This process includes the notification to the provider of the determination, and the appeal process. Provider complaints may be considered either a grievance or an appeal.

MCO Provider Grievance Process

A provider grievance is an expression of dissatisfaction that is not regarding an action or adverse decision. Maryland Physicians Care has a written grievance process whereby a provider who is dissatisfied with the MCO may seek resolution verbally or in writing by contacting Maryland Physicians Care’s Provider Relations Department at 1-800-953-8854, Option 2, Option 3 or via email.

Maryland Physicians Care recognizes the importance of distinguishing between provider grievances that are time-sensitive, which must be addressed on an expedited basis. Provider grievances may be considered emergent, urgent or administrative in accordance with the State-

defined timeframes listed below. Emergent provider grievances are addressed within 24 hours of receipt, urgent provider grievances are addressed within 48 hours of receipt, and Administrative provider grievances are addressed within 30 days of receipt.

Provider written grievances may be submitted to the attention of the Provider Relations Department at Maryland Physicians Care 509 Progress Drive, Suite 117, Linthicum, Maryland 21090

MCO Provider Appeals

Maryland Physicians Care has a process regarding provider appeals as a request for a review of an action-related to claims denials. Appeals for service denials, reductions or terminations are considered member appeals and follow the MCO member appeal process. Maryland Physicians Care requires all provider appeals to be submitted in writing to the attention of the Appeals Department at the Maryland Physicians Care, 509 Progress Drive, Suite 117, Linthicum, Maryland 21090.

Timeframes related to the appeals process

- Providers have 90 business days to file an appeal from the date of claim denial.
- MPC acknowledges provider written appeals within five business days of its receipt.
- Providers are allowed 30 days from the date of MPC's appeal determination to file one subsequent level of appeal for consideration. Second level appeals must include additional information or documentation for consideration.
- MPC resolves denial of payment appeals (including a second level appeal within 90 business days of receipt of the initial appeal by MPC.
- Previously denied claims are paid within 30 days of the appeal decision when a claim denial is overturned.
- MPC furnishes written notification of its appeal determination with 90 business days of receipt of the initial appeal.

We will not take any punitive action against a provider for utilizing our provider complaint process.

Completing the CMS 1500

The CMS 1500 form is used to bill professional services provided to members. The following is a field-by-field description of the items listed below used by the Claims Department for reimbursement. The number of the field corresponds with the field number on the CMS 1500 claim form. When filing a claim on a CMS 1500, there are certain fields on the form that are required to be complete (bolded and italicized) and others that are required if applicable (i.e., other insurance).

CMS 1500 Form:

Field #	Field Title	Field Description
ITEM 1	PROGRAM	This field shows all type(s) of health insurance coverage applicable to this claim.
ITEM 1a	INSURED ID NUMBER	This is the member MCO Identification number.
ITEM 2	MEMBER NAME	This is where the MCO member's name is displayed.
ITEM 3	BIRTH DATE	This is the birth date and sex of the member. This data is used to verify that this is a MCO enrolled member.
ITEM 4	INSURED NAME	If the health insurance is under another person's name (e.g., child covered under a parent's health insurance), the insured name is listed here.
ITEM 5	MEMBER ADDRESS	Members address (Street or P.O. Box, city and zip code) Another possible verification for member name and ID number.
ITEM 6	MEMBER RELATIONSHIP TO INSURED	This indicates the relationship of the member to the insured (e.g., spouse, child or other relation).
ITEM 7	INSURED ADDRESS	Another possible verification for member name and ID number. Required only when item 4, 10 or 11 is completed.
ITEM 8	MEMBER STATUS	This indicates the member's marital status and whether employed or a student.
ITEM 9	OTHER INSURED NAME	If Applicable - If the contract for services is under another persons name (e.g., child covered under a parent's contract) in addition to the one listed in item 4, the insured's name is listed here.
ITEM 9a	OTHER INSURED GROUP/POLICY NUMBER	If Applicable - This will indicates the other insured's group policy number.
ITEM 9b	OTHER INSURED DOB & SEX	If Applicable - This lists the other insured's date of birth and sex for verification.
ITEM 9c	OTHER INSURED EMPLOYER OR SCHOOL	If Applicable - This lists the name of the employer or school under which this coverage is provided.
ITEM 9d	OTHER INSURED PLAN OR PROGRAM NAME	If Applicable - This identifies the other carrier.
ITEM 10	WAS THE CONDITION RELATED TO:	This identifies if the claim is work related, due to an auto accident or other type of accident.
ITEM 11	INSURED GROUP/POLICY NUMBER	Insured's policy group or FECA number
ITEM 11a	INSURED DOB & SEX	Insured's date of birth and sex for verification.
ITEM 11b	INSURED EMPLOYER OR SCHOOL	Employer's name or school name
ITEM 11c	INSURED PLAN OR PROGRAM NAME	Insurance plan name or program name.
ITEM 11d	OTHER HEALTH BENEFIT PLAN COVERAGE	Other health benefit plan coverage document.
ITEM 12	MEMBER'S SIGNATURE	Member signature or notation that the signature is on file. This authorizes the provider to release any medical information necessary to process the claim.

CMS 1500 Form:

Field #	Field Title	Field Description
ITEM 13	INSURED SIGNATURE	Signature or notation that the signature is on file. This authorizes the insurance carrier to release payment directly to the provider.
ITEM 14	DATE OF CURRENT	This is the date of current illness, injury or pregnancy for use in determining pre-existing conditions.
ITEM 15	DATE OF PREVIOUS	This is the date of same or similar illness, injury or pregnancy for use in determining pre-existing conditions.
ITEM 16	DATES UNABLE TO WORK	Dates the member was unable to work.
ITEM 17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	This is the name of the referring physician.
ITEM 17a	ID NUMBER OF REFERRING PHYSICIAN	This is the ID number of the referring physician.
ITEM 17b	NPI NUMBER OF REFERRING PHYSICIAN	This is the NPI number of the referring physician.
ITEM 18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICE	This indicates any related inpatient stays.
ITEM 19	NATIONAL PROVIDER INDICATOR	Temporary site until HCFA 1500 is updated by CMS
ITEM 20	OUTSIDE LAB	This indicates laboratory services were provided outside of the office but are included in this billing.
ITEM 21	DIAGNOSIS OR NATURE OF ILLNESS	This is where the provider lists the general diagnosis(s) of the member using current ICD-9 codes.
ITEM 22	CLAIM RE-SUBMISSION	This is where the provider will indicate the original remit code and claim number if this is a re-submission of a previously processed claim.
ITEM 23	PRIOR-AUTHORIZATION NUMBER	If the service/procedure requires prior authorization, this is where the MCO PA Number is indicated for processing.
ITEM 24a	DATE OF SERVICE(s)	This indicates the date(s) that services were provided. Date spans are not acceptable (unless specifically allowed by contract). Each individual date needs to be billed on a separate line.
ITEM 24b	PLACE OF SERVICE	This indicates where the service took place (e.g., doctor's office, inpatient hospital, outpatient hospital, etc.)
ITEM 24c	TYPE OF SERVICE	This indicates the type of service provided (e.g., surgery, anesthesia etc.)
ITEM 24d	PROCEDURE, SERVICES OR SUPPLIES	This indicates the service provided using current HCPCS/CPT codes with modifiers as appropriate.
ITEM 24e	DIAGNOSIS	This indicates the specific diagnosis the procedure was to treat. Should also be listed in item 21.
ITEM 24f	CHARGES	This is the amount the provider is billing for the service provided. (If a provider is contracted for capitated services, all encounters must be submitted with a dollar amount. For capitated services, please do not enter zero or no charge for amount billed.)

CMS 1500 Form:

Field #	Field Title	Field Description
ITEM 24g	DAYS OR UNITS	If the provider provided this service over a number of days or in excess of a single unit, the quantity will be listed here.
ITEM 24h	FAMILY PLANNING	This indicates if the services provided were related to the Family Planning programs.
ITEM 24i	EMG	This is used to identify if the service was rendered in a hospital emergency room. If this item is checked, the place of service code in item 24b should match.
ITEM 24j	HEALTHCHOICE NUMBER	The HealthChoice Provider ID Number
ITEM 24k	RESERVED FOR LOCAL USE	
ITEM 25	FEDERAL TAX ID NUMBER	The number is assigned to the provider by the Federal Government for tax reporting purposes.
ITEM 26	MEMBER ACCOUNT NUMBER	The provider's office uses this to reference member's account files.
ITEM 27	ACCEPTS ASSIGNMENT	This field is completed if the physician/supplier accepts assignment of Medicare benefits.
ITEM 28	TOTAL CHARGE	This is the total amount the provider is billing for the services provided.
ITEM 29	AMOUNT PAID	This is the amount paid by any other payor or co-payment. This amount is documented on the attached Explanation of Benefits.
ITEM 30	BALANCE DUE (IF DIFFERENT THAN ITEM 28)	This indicates the amount due after any deductions for other payors.
ITEM 31	SIGNATURE OF PROVIDER	This must be indicated. The signature of the provider who provided the service. The acceptable signatures are as follows: Provider's signature or Provider's signature rubber-stamped, or Computer generated claim form with the provider's name in BLOCK LETTERS.
ITEM 32	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED	This is the location the actual services were provided. This may match the billing address listed in item 33.
ITEM 32a	NPI NUMBER OF PROVIDER IN ITEM 32	Service Location
ITEM 33	BILLING ADDRESS	This is required information to include where the reimbursement will be mailed. Pay-to address must be the same as Form W-9. The MCO provider identification number for physicians is their medical License Number, and for other providers the TIN.
ITEM 33a	GROUP NPI NUMBER	The Pay-To NPI Number for the group
ITEM 33b	GROUP HEALTHCHOICE NUMBER	The HealthChoice Number for the group (If applicable)

Reporting Communicable Disease

A provider must ensure that all cases of reportable communicable disease that are detected or suspected in an enrollee by either a clinician or a laboratory are reported to the local health department (LHD) as required by Health - General Article, Sections 18-201 to 18-216, Annotated Code of Maryland and COMAR 10.06.01 Communicable Diseases and related conditions of Public Health importance.

A physician or other health care provider with reason to suspect that an enrollee has a reportable communicable disease or condition that endangers public health, or that an outbreak of a reportable communicable disease or public health-endangering condition has occurred, must submit a report to the health officer for the jurisdiction where the provider cares for the enrollee.

- The provider report must identify the disease or suspected disease on a form provided by the Department (DHMH1140) or as directed by COMAR 10.06.03 and .04
- With respect to patients with tuberculosis, the provider must report each confirmed or suspected case of tuberculosis to the LHD within 48 hours, and provide treatment in accordance with the goals, priorities, and procedures set forth in the most recent edition of the Guidelines for Prevention and Treatment of Tuberculosis, published by DHMH.

Other Reportable Diseases and Conditions

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

Reportable Communicable Diseases - Laboratory Providers

Providers of laboratory services must report positive laboratory results as directed by Health - General Article Section 18-205, Annotated Code of Maryland.

In order to be in compliance with the Maryland HIV/AIDS reporting Act of 2007, Laboratory providers must report HIV positive members and all CD4 test results to the Health Department by using the member's name. The State of Maryland HIV/CD4 Laboratory Report Form DHMH 4492 must be used. The reporting law and the revised reporting forms may be found at the following website: **[Http//dhmh.state.md.us/AIDS/HivReporting/HivReport](http://dhmh.state.md.us/AIDS/HivReporting/HivReport)**.

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

Maryland Physicians Care cooperates with Local Health Departments in investigations and control measures for communicable diseases and outbreaks.

Following is a list of reportable communicable diseases:

Amebiasis	Microsporidiosis
Anaplasmosis	Mumps (infectious parotitis)
Animal bites	Mycobacteriosis, other than tuberculosis and leprosy)
Anthrax	Novel influenza A virus infection
Arboviral infections	Pertussis
Babesiosis	Pertussis vaccine adverse reactions
Botulism	Pesticide related illness
Brucellosis	Plague
Campylobacter infection	Pneumonia in a healthcare worker resulting in hospitalization
Chancroid	Poliomyelitis
Chlamydia infection	Psittacosis
Cholera	Q Fever
Coccidioidomycosis	Rabies
Creutzfeldt-Jakob disease	Ricin toxin
Cryptosporidiosis	Rocky Mountain spotted fever
Cyclosporiasis	Rubella (German measles) and congenital rubella syndrome
Dengue fever	Salmonellosis (non-typhoid fever types)
Diphtheria	Septicemia in newborns
Ehrlichiosis	Severe acute respiratory syndrome (SARS)
Encephalitis	Shiga-like toxin producing enteric bacterial infections
Epsilon toxin of Clostridium perfringens	Shigellosis
Escherichia coli O157:H7 infection	Smallpox and other Orthopoxvirus infections
Giardiasis	Staphylococcal enterotoxin B
Glanders	Streptococcal invasive disease, Group A
Gonococcal infection	
Haemophilus influenzae, invasive disease	
Hantavirus infection	
Harmful algal bloom related illness	
Hemolytic uremic syndrome, post-diarrheal	

Hepatitis, Viral (A,B,C, Delta, non-ABC,
E, F, G, undetermined)
Influenza-associated pediatric mortality
Isosporiasis
Kawasaki syndrome
Legionellosis
Leprosy
Leptospirosis
Listeriosis
Lyme Disease
Malaria
Measles (rubeola)
Melioidosis
Meningitis, infectious
Meningococcal invasive disease

Stereptococcal invasive disease, Group B
Streptococcus pneumoniae, invasive disease
Syphilis
Tetanus
Trichinosis
Tuberculosis and suspected tuberculosis
Tularemia
Typhoid fever (case or carrier, or both, of
Salmonella typhi)
Vancomycin-intermed Staph Aureus (VISA)
Vancomycin-resistant Staph (VRSA)
Varicella (chickenpox), fatal cases only
Vibriosis, non-cholera types
Viral hemorrhagic fever (all types)
Yellow fever
Yersiniosis



Section III
PAC Benefits and Services

Overview of Benefits

Below is a summary of key points about PAC enrollee benefits.

- Prior to MCO enrollment, PAC enrollees get their prescription drugs and mental health services using their yellow and white Medicaid fee-for-service card.
- After the enrollee is in an MCO, prescription drugs, except most mental health drugs and HIV/AIDS drugs, will be the responsibility of Maryland Physicians Care.
- After the enrollee is in Maryland Physicians Care, certain mental health drugs which have multiple uses will be the responsibility of Maryland Physicians Care.
- Coverage for primary care and certain services for PAC enrollees with diabetes begin once the enrollee is in Maryland Physicians Care.
- Specialty care, in-patient and outpatient hospital services are not covered for PAC enrollees by either the State or by Maryland Physicians Care.
- After MCO enrollment, primary mental health services will be the responsibility of Maryland Physicians Care.
- The PCP must bill Maryland Physicians Care for primary care services. State Medicaid does not pay claims from PCPs or reimburse PCPs for services to PAC enrollees.
- The PCP serves as the entry point for access to health care services. The PCP is responsible for providing PAC enrollees with medically necessary covered services and making appropriate referrals for specialty care.
- The PCP is responsible for maintaining medical records and coordinating comprehensive medical care for each assigned enrollee.
- Benefits and services are covered only if medically necessary.
- PAC enrollees have the right to access family planning services without any prior referral or authorization by the PCP. Maryland Physicians Care is responsible for reimbursing out-of-network providers who have furnished these services.

- PAC enrollees have coverage for routine Gynecological services. If the PCP does not perform GYN exams, Maryland Physicians Care will arrange for the service through another network provider.
- Maryland Physicians Care cannot restrict access to needed drugs and related pharmaceutical products by requiring PAC enrollees to use mail-order pharmacy providers.
- PAC enrollees may not be charged any co-payments, premiums or cost sharing of any kind, except as specifically allowed by law.
- Maryland Physicians Care charges PAC enrollees (insert co-pay info - up to a \$2.50 co-payment for generic drugs and up to a \$7.50 co-payment for brand-name drugs.)
- If a PAC enrollee does not pay the co-pay assessed by Maryland Physicians Care, the pharmacist may refuse to fill the prescription. (Note: This policy differs from HealthChoice and regular Medicaid.)
- Maryland Physicians Care does not charge pharmacy co-payments during pregnancy or for family planning drugs and devices.

MCO Covered Benefits and Services

Dental Care Services

Maryland Physicians Care (MPC) MCO offers a value added routine dental benefit. Effective October 1, 2007, PAC members 19 years of age and older are eligible for a dental benefit that includes preventative dental care with some basic restorative services without Prior Authorization, to include:

- Exams
- Cleanings
- Fillings
- X-rays
- Extractions

The PAC dental benefit is managed by MPC's dental vendor, DentaQuest which may be contacted at (800) 936-0935. Please contact DentaQuest or access MPC's website at www.MarylandPhysiciansCare.com for addition information regarding this value added benefit.

Diabetes Care Services

Maryland Physicians Care covers the following diabetes care services for enrollees who have diabetes:

- 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; and
 - Diagnostic reagent strips and tablets used for testing for ketone and glucose in urine and glucose in blood; and
- Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear.

Any preauthorization required by the MCO for DME and/or DMS must be provided in a timely manner so as not to adversely affect the enrollee's health and within 2 days of receipt of necessary clinical information but no later than 7 days after the initial request.

Diagnostic Radiology Services

Maryland Physicians Care covers the following diagnostic radiology services:

- Chest x-rays;
- Mammograms;
- X-rays needed to diagnose suspected fractures.

NOTE: Maryland Physicians Care MCO is offering an added-value benefit for hospitals in the following counties: Allegany, Garrett, Washington, Frederick Calvert, St. Mary's, Charles and all counties on the Eastern Shore. There are NO other hospital benefits for the PAC program. Hospital outpatient mammograms are an exception benefit. This change was implemented to allow access to mammograms for patients in areas where free standing radiology services are unavailable.

Maryland Physicians Care MCO will permit mammograms performed as a hospital outpatient service. For billing purposes, the codes covered under this benefit will be 0401, 0403, 76090, 76091, 76092, 77055, 77056, 77057.

Prior Authorization will be required for this benefit when rendered in a hospital outpatient setting, for both participating and non-participating hospitals.

- To contact MPC's prior authorization department by phone, call 1-800-953-8854, ext. 2, ext. 1.
- Or fax your prior authorization request to 800-953-8856.

Electrocardiogram Testing

Maryland Physicians Care covers medically necessary electrocardiogram (EKG) testing.

Emergency Department Services

Maryland Physicians Care covers true medical emergencies (facility only). Services are not covered if member is admitted.

Family Planning Services

Maryland Physicians Care covers comprehensive family planning services, with the exception of permanent sterilization. This includes:

- Office visits for family planning services;
- Laboratory tests including pap smears; and
- All FDA approved contraceptive devices, such as IUDs, diaphragms, patches, injectables, pills, and condoms.

Pharmacy - Formulary Requirements

- Maryland Physicians Care is required to expand the drug formulary to include new products approved by the Food and Drug Administration (FDA). In

addition Maryland Physicians Care must maintain a drug formulary that is at least equivalent to the standard benefits of the Maryland Medical Assistance Program. This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high risk and special needs populations and vaccines prescribed to protect individuals against vaccine-preventable diseases. If a generic equivalent drug is not available, new brand name drug rated as P (priority) by the FDA will be added to the formulary.

- Coverage may be subject to preauthorization to ensure medical necessity for specific therapies. For formulary drugs requiring preauthorization by Maryland Physicians Care or its designee, a decision must be made within 72 hours after the initial request. If the service is denied, Maryland Physicians Care will notify the prescriber and the enrollee in writing of the denial.
- When a prescriber believes that a non-formulary drug is medically indicated, MCOs must have procedures in place for non-formulary requests. The Program expects a non-formulary drug to be approved if documentation is provided indicating the formulary alternative is not effective. Requests for non-formulary drugs cannot be automatically denied or delayed with repeated requests for additional information. The MCOs must follow an established reasonable review time for all non-formulary requests to comply with the minimum performance standards for drug use management programs established by the Department.
- When a prescriber believes that a non-formulary drug is medically indicated, Maryland Physicians Care MCO has procedures in place for non-formulary requests. The Program expects a non-formulary drug to be approved if clinical notes document that the formulary agent is contraindicated or has not been effective. Requests for non-formulary drugs cannot be automatically denied or delayed with repeated requests for additional information. Maryland Physicians Care MCO must follow an established reasonable review time for all non-formulary requests to comply with the minimum performance standards for drug use management programs established by the Department.

Laboratory Services

Maryland Physicians Care covers the following diagnostic services, and laboratory services performed by a CLIA-certified provider:

- Complete blood count (CBC);
- Chemistry panel including lipid profile and TSH;
- Urinalysis, including toxicology screenings;
- Urine culture and sensitivity studies;
- Pregnancy testing;
- PAP/cytology test for cervical cancer;
- Prostate-specific antigen (PSA);
- Fecal occult blood;
- Testing to detect sexually-transmitted infections (STIs);
- Hemoglobin A1C;
- Blood glucose;
- Glucose tolerance testing;
- Therapeutic drug monitoring, excluding viral load testing, genotypic, phenotypic, or other HIV/AIDS drug resistance testing.

Pharmacy Services

Maryland Physicians Care covers all pharmaceutical services and pharmaceutical counseling when ordered by the PCP or any authorized prescriber. This includes:

- Legend (prescription) drugs
- Insulin
- Contraceptives
- Latex condoms (to be provided without any requirement for a provider's order)
- Hypodermic needles and syringes for diabetics
- Enteric coated aspirin prescribed for treatment of arthritic conditions
- Medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for an enrollee by a qualifying provider
- Most mental health drugs are the responsibility of the Public Mental Health System. The mental health drugs which are the responsibility of Maryland Physicians Care are listed on page 47.
- Iron for anemia
- Ferrous Sulfate

HIV/AIDS drugs are not covered by Maryland Physicians Care but are covered by the State.

Pharmacy Limitations

Neither the State nor Maryland Physicians Care will cover the following:

- 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;
- Ovulation stimulants;
- Enteral nutritional and supplemental vitamins and mineral products given by nasogastric, jejunostomy, or gastrostomy tube;
- Medical supplies for compounding prescriptions for home intravenous therapy.
- When a prescriber believes that a non-formulary drug is medically indicated, Maryland Physicians Care MCO has procedures in place for non-formulary requests. The Program expects a non-formulary drug to be approved if clinical notes document that the formulary agent is contraindicated or has not been effective. Requests for non-formulary drugs cannot be automatically denied or delayed with repeated requests for additional information. Maryland Physicians Care MCO must follow an established reasonable review time for all non-formulary requests to comply with the minimum performance standards for drug use management programs established by the Department.

Primary Care Services

Primary care encompasses care which is generally received from the enrollee's PCP. The PCP acts as a coordinator of care, and has the responsibility to provide accessible, continuous, comprehensive, and coordinated primary health care services covering the scope of services which a PAC enrollee is eligible for. Primary care services include:

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

Family planning and routine gynecological services are considered primary care. For family planning services, women can opt to go to an out-of-plan provider without a referral from the PCP and Maryland Physicians Care will pay for the service. However, for routine gynecological services, Maryland Physicians Care requires that the enrollee either use the PCP for this service or go to a network provider. Gynecological care related to the diagnosis and treatment of a problem that is outside the scope of practice of a primary care provider are not covered by PAC.

Primary Mental Health Services

Primary Mental Health Services are provided by the PCP.

Maryland Physicians Care covers primary mental health services, including clinical evaluation and assessment, provision of primary mental health services, and/or referral for additional services, as appropriate.

The PCP may elect to treat the PAC enrollee, regardless of the diagnosis and severity of illness, if the treatment falls within the scope of the PCP's practice, training, and expertise. These services are included in Maryland Physicians Care rates; therefore neither the PCP nor Maryland Physicians Care may bill the Public Mental Health System (PMHS) for the provision of such services.

When, in the PCP's judgment, a PAC enrollee has a need for mental health treatment that cannot be adequately addressed by the PCP, the PCP should refer the enrollee to the Public Mental Health System for specialty mental health services. The toll-free help line is 1-800-888-1965.

Self-Referral Services

An out-of-plan provider at Maryland Physician Care MCO's expense may at the enrollee's option, deliver some covered services, which are subject to capitation. The services that an enrollee has the right to access on a self-referral basis include:

- Certain family planning services including office visits, diaphragm fitting, IUD insertion and removal, special contraceptive supplies, Norplant, Norplant insertion and removal, depo-provera-FP, latex condoms and PAP smear
- Pharmaceutical and laboratory services, when provided in connection with a legitimately self-referred service, provided on-site where the self-referred services were performed, and by the same out-of-plan provider

Substance Abuse Services

Enrollees may self refer for the following substance abuse services:

- assessment
- family group and individual counseling
- methadone treatment
- community based intensive outpatient treatment

Providers must follow Maryland Physicians Care's authorization and notification requirements. Enrollees must meet ASAM criteria. See COMAR 10.09.76.10F or contact Maryland Physicians Care for details.

Services Requiring Prior Authorization

Maryland Physicians Care will require prior authorization for the following services:

- Finger sticking devices
- Blood glucose meters, Blood glucose monitoring supplies, Test strips
- Compression stockings
- Crutches and canes, Walkers
- Non-custom orthotic inserts
- Routine foot care for enrollees with vascular disease affecting the lower extremities
- All podiatry services
- *Mammograms - done in a rural hospital outpatient facility only*

To request prior authorization, please contact the Maryland Physician Care Prior Authorization Line at **1-800-953-8854** or fax your request at **1-800-953-8856**.

Vision Care Services

Maryland Physicians Care (MPC) MCO offers a value added routine vision benefit. Effective January 1, 2008, PAC members 19 years of age and older are eligible for a vision benefit that includes one eye examination by an ophthalmologist and one pair of eyeglasses per year

The PAC vision benefit is managed by MPC's vision vendor, Block Vision which may be contacted at (800) 428-8789. Please contact Block Vision or access MPC's website at www.MarylandPhysiciansCare.com for addition information regarding this value added benefit

General Limitations

The following are examples of services which are not covered even when rendered by the PCP:

- Medical care beyond the scope of primary care;
- 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;
- Services performed before the effective date of the enrollee's coverage in Maryland Physicians Care;
- Abortions (including medical abortions) and fertility treatments;
- Diet and exercise programs for weight loss; and
- Immunizations for travel outside the U.S.

Examples of Non-Covered Services

PAC enrollees only get the benefits listed previously. The following are examples of the types of services which are not covered by PAC:

- Abortions;
- Audiology and hearing aids;
- Blood and blood products;
- Case management;
- Dental care, including general and emergency, and orthodontia services;
- Diet, exercise, and weight reduction programs;
- Fertility treatments
- Hospice care;
- Hospital services, **except emergency facility services**;
- Immunizations for travel outside the U.S.;
- Nursing home or long-term care ;
- Oxygen and respiratory equipment;
- Personal care, home health, private duty nursing, and medical day care;
- Pregnancy-related services (Note: PAC enrollees who become pregnant should qualify for full benefits, including pregnancy care, under the Maryland Children's Health Program);
- Rehabilitation services (i.e., OT, PT, and Speech Therapy);
- Services provided by specialists;
- Services in an ambulatory surgical center;
- Transportation services; and
- Viral load testing, genotypic, phenotypic or HIV/ AIDS drug resistance testing.



Section IV

**Specialty Mental Health Services and the
Public Mental Health System**

Overview of Specialty Mental Health Services

Prior to enrollment in the MCO, PAC enrollees must access all mental health services through the Public Mental Health System (PMHS). As in HealthChoice, the Mental Hygiene Administration (MHA), in collaboration with core service agencies (CSA), operates the Public Mental Health Services system. MHA contracts with an Administrative Services Organization (ASO). The ASO provides administrative management functions for all CSAs Statewide.

After a PAC enrollee is in an MCO, the PMHS is only responsible for specialty mental health services. Primary mental health services are the responsibility of Maryland Physicians Care. Read pages 39 and 46 for more information. Specialty Mental Health Services (SMHS) are discussed below.

Access to Specialty Mental Health Services

- SMHS (i.e., any mental health services other than primary mental health services) are not subject to capitation and are not Maryland Physicians Care responsibility with regard to payment. However, Maryland Physicians Care and/or the PCP does have the responsibility to refer appropriately eligible enrollees to the PMHS when specialty mental health services are needed.
- An enrollee with a probable diagnosis of a mental disorder is eligible for referral to the PMHS by the PCP or Maryland Physicians Care if the following conditions are met:
 - The enrollee's probable diagnosis of a mental disorder was established in accordance with the current American Psychiatric Association Diagnostic and Statistical Manual recognized by DHMH;
 - The probable diagnosis is not a sole diagnosis of substance abuse or dependence, dementia, or mental retardation or one of the diagnoses listed in on page 47 under the heading of **Mental Health Diagnoses Covered By Maryland Physicians Care MCO**
 - The PCP or Maryland Physicians Care determines that primary mental health services provided by the PCP are insufficient to address the enrollee's mental health treatment needs.
- A mental health professional functioning as the SMHS utilization review (UR) agent will conduct preauthorization to determine the medical necessity for mental health assessment or treatment. The SMHS UR agent will preauthorize medically necessary services of a type, frequency, and duration that are consistent with expected results

and cost-effective.

- If the SMHS UR agent determines that there is medical necessity for specialty mental health services, the enrollee will be linked with the appropriate services.
- If the SMHS UR agent determines that specialty mental health services are not medically necessary, the SMHS UR will, as appropriate, promptly consult with Maryland Physicians Care and (if involved) the PCP or other provider, for assistance in developing a plan for the enrollee, to determine whether an alternative service or a service of alternate duration is appropriate.
- If the SMHS UR agent denies services, the enrollee, or the PCP will be notified orally or in writing, specifying the clinical rationale for the denial, and outlining procedures for appealing the denial.
- The SMHS UR agent may not deny services without arranging an appropriate alternative service if the denial of services would abruptly change the enrollee's living situation or cause severe disruption to a enrollee with serious and persistent mental illness or serious emotional disturbance.

Referring Enrollees to the SMHS Toll-Free Help Line

The PMHS toll-free helpline, 1-800-888-1965, is available 24 hours a day, 7 days a week. It is staffed by mental health clinicians called Care Managers. Care managers are licensed mental health professionals in accordance with Maryland's Health Occupation Act.

Enrollees can access the helpline directly or through assistance from Maryland Physicians Care, PCP, mental health provider, family enrollee or caregiver. The help line staff is trained to handle those who are non-English speaking or hearing impaired. Physician advisors are also available at all times. The helpline is highly publicized to recipients, family enrollees, providers and the MCOs.

Once a call is received by the helpline, Care Managers assess requests for service using the following definitions of need:

- **Acute Crisis**- A situation in which an enrollee is threatening imminent harm to self or another. The enrollee or the person making the call may state or imply that the enrollee is not in control of these impulses. Help must be dispatched immediately, while keeping the caller on the line with a clinician. The Care Manager will keep the caller on the line without placing him or her on hold, and will have another staff member place a 911 call using a separate line.

- **Emergency-** A situation involving an enrollee (or the person making the call) who states or implies that the enrollee may do harm to self or another person if help is not received soon. The enrollee (or person calling) states or implies the enrollee's need for help, but may be able to maintain impulse control for several hours until help can be arranged. The Care Manager's assessment of the situation presented is that acute crisis services would not be needed. In these cases, the PMHS protocols will require that authorizations are made within one hour and face-to-face emergency services must be provided within four hours.
- **Urgent** - A situation in which the enrollee is experiencing a decrease in self-control and increasing frustration over life events. The Care Manager's assessment is that neither acute crisis nor emergency services are needed. As a result, the enrollee plans or engages in avoidance activities, such as running away, rather than threatening harm to self or others. The PMHS protocols require that an urgent situation be handled through face-to-face services within 24 hours.
- **Scheduled-** A situation in which the enrollee or caller feels that the enrollee is in no immediate harm, but requires an assessment and probable mental health services. The PMHS system's protocols require that enrollees be seen by a provider within 10 working days.

In addition, the PMHS will be available to arrange for medically appropriate psychiatric consultations for any condition.

Specialty Mental Health Service Limitations

While enrollees may access the full range of specialty mental health services, there are some SMHS, such as in-patient care, partial hospitalization and rehabilitation services, which are not part of the PAC benefit package. PAC enrollees are considered uninsured for those SMHS that are not part of the PAC benefit package. They may be charged on a sliding fee basis for non-covered services.

Specialty Mental Health Diagnoses Covered by the PMHS

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

Mental Health Diagnoses Covered By Maryland Physicians Care MCO

<u>ICD-9CM Code</u>	<u>Description</u>
294.0	Amnestic syndrome
294.8	Other specified organic brain syndromes (chronic)
294.9	Unspecified organic brain syndromes (chronic)
299.00-299.91	Psychoses with origin specific to childhood
301.7	Antisocial personality disorder
302.70-302.79	Psychosexual dysfunction
306.0-306.9	Physiological malfunction arising from mental factor
307.0	Special symptoms of syndromes, not elsewhere classified (NEC)
307.2	Tics
307.40-307.49	Specific disorders of sleep of nonorganic origin
307.09	Other and unspecified special symptoms or syndromes NEC
316	Psychic factors associated with disease classified elsewhere



Section V
Enrollee Information

Enrollee Rights and Responsibilities

Maryland Physicians Care (MPC) MCO believes that having a good relationship with our members is important. We believe the following rights and responsibilities are necessary for a good relationship.

Enrollees have the right to:

- Be treated with respect and dignity.
- Not have your medical records shown to others without your okay, unless allowed by law.
- Privacy when you are at office visits or getting treatment.
- Get information about MPC, our services, the practitioners that provide care, and Member Rights and Responsibilities.
- Talk to your health care provider about medical treatments for your conditions. Talk to them even if the treatment costs a lot or is not a covered benefit.
- Know about your health condition. Know the plans to treat you. Know what could happen after your treatment.
- Find out what is in your medical records, as allowed by law.
- Be a part of deciding on the kind of care you want or do not want.
- Get the MPC Member Handbook. It will tell you about our services, member rights and responsibilities, and how to file a complaint or grievance.
- Voice your complaints and grievances about MPC and the care you get from your provider.
- Use the methods listed in MPC's Handbook to present questions and concerns about your health care or MPC.
- Pick a doctor who works with MPC or refuse care from certain providers.
- Tell us ways to improve MPC policies and procedures.
- Develop Advance Directives.
- Get covered benefits or services, regardless of gender, race, age, religion, origin, physical or mental disability, or type of illness or condition.

Enrollees have a responsibility to:

- Read this handbook. Follow the rules.
- Show your ID card to each doctor before getting health services.
- Make and keep appointments with providers. If you need to cancel appointments, it must be done at least 24 hours before your scheduled visit.
- Give all information about your health to MPC and your doctor.
- Tell your doctors if you do not understand what they tell you about your health.
- Follow what your doctor tells you. Make follow-up appointments. Take medicines. Follow other orders.
- Schedule wellness check-ups.
- Get care as soon as you know you are pregnant. Keep all prenatal appointments.
- Tell MPC and the Department of Health and Mental Hygiene when your address changes. Tell them about changes in your family that might affect eligibility or enrollment.
- Tell MPC if you have other health insurance, including Medicare.

Americans with Disabilities Act

Maryland Physicians Care MCO shall accommodate individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990, P.L. 101-330, 42 U.S.C. §12101 et seq., and regulations promulgated under it. Please read Section II: Provider Responsibilities for Maryland Physicians Care policies and procedures on the act.

Communication Access

Getting an Interpreter for Those Who Do Not Speak English

Maryland Physicians Care (MPC) MCO wants to make sure that all of our members can access our services. Those members who do not speak English as their main language may still call the MPC Customer Services Department. MPC will link the call with the AT&T translation service for any language need. A member can even call for this help when visiting your office.

Getting an Interpreter for Those Who Are Hearing Impaired

For those members of Maryland Physicians Care who are hearing impaired or need the help of a TDD line, MPC will use the services of Maryland Relay Service. To contact any Maryland Physicians Care department, please contact Maryland Relay at 1-800-735-2258.

They can interpret for the member on the call to the Maryland Physicians Care Member Solutions Department at 1-800-953-8854.

Provider offices may also contact MPC Member Solutions to arrange a hearing impaired interpreter to be available at the time of the scheduled appointment.

Cultural Competency

Maryland Physicians Care (MPC) MCO shall provide access to health care services and information in a manner that addresses the individualized needs of its enrollees, including, but not limited to, the delivery of services and information to enrollees: In a culturally sensitive manner that facilitates an understanding of MPCs benefits package and how to access care, and generally enhances communication between enrollees and their health care providers.

Procedure for Selecting a PCP

How Do I Choose My PCP?

When a member joins Maryland Physicians Care (MPC) MCO, the member can pick the PCP he or she wants for themselves and their eligible family members. If the member did not pick you as a PCP, the member can call us and ask to change their doctor. The member must pick you from the Maryland Physicians Care Provider Directory.

The Customer Services Department will help the member if help is necessary to:

- Pick a doctor
- Receive more information about the doctors and other providers on MPC
- To receive care if the member cannot reach you
- A provider directory

Procedure for Changing PCPs

How Do I Change My PCP?

The members' PCP is an important part of the medical care team. If the member has any questions about their care, the member should address these questions to their PCP. We want the member and the PCP to work together. The member may wish to change doctors and may do so at any time. If so, the member may call or write to the Customer Services Department to request the change. The member will get a new ID card within 10 days.

Maryland Physicians Care (MPC) MCO Complaint, Grievance and Appeal Processes

Maryland Physicians Care MCO Consumer Hotline

Maryland Physicians Care MCO maintains a member services unit that operates a consumer services hotline at least during normal business hours. The MPC customer service staff will resolve or properly refer a Member's inquiry or complaint to the appropriate agency. They will also provide the member with information about how to access additional services through the MPC member services unit. Maryland Physicians Care MCO must also provide the member with the State's Enrollee Action Line number for PAC Members- 1-888-754-0095. Read pages 36 - 38 for information on DHMH's Complaint and Appeal Processes.

Maryland Physicians Care MCO Enrollee Grievance Policy and Procedures

Maryland Physicians Care MCO has a written grievance policy and procedures whereby a Member who is dissatisfied with MPC or its network may seek recourse verbally or in writing. Maryland Physicians Care MCO internal grievance materials have been developed in a culturally sensitive manner, at a suitable reading comprehension level, and if the enrollee is a member of a substantial minority, in the enrollee's native tongue. Maryland Physicians Care MCO provides a copy of its grievance policy and procedures to each new enrollee with MPC's initial mailing and at any time upon an enrollee's request.

Maryland Physicians Care MCO must assure that providers are allowed to participate on behalf of the enrollee in the grievance process and that providers receive a copy of Adverse Action Letters when disputed services are reduced or denied. No punitive action will be taken against the enrollee or the provider for making a complaint against MPC or the Department.

The timeframe in which MPC must resolve complaints is as follows: (1) emergency medically related complaints are to be resolved within 24 hours; (2) non-emergency medically related complaints are to be resolved within five days; and administrative complaints are to be resolved within 30 days. Read pages 55-56 for information on DHMH's Complaint and Appeal Processes.

MCO Complaint Process

REQUIREMENTS - The MCO's written internal complaint policies and procedures are subject to the approval of the Department.

MCO Consumer Hotline

The MCO must maintain an enrollee services unit that operates an enrollee services hotline at least during normal business hours. The MCO customer service staff will resolve or properly refer an enrollee's inquiry or complaint to the appropriate agency. They will also provide the enrollee with information about how to access additional services through the MCO enrollee services unit. The MCO must also provide the enrollee with the State's Enrollee Help Line number for PAC enrollees- 1-888-754-0095. Read pages 53-55 for information on DHMH's Complaint and Appeal Processes.

MCO Enrollee Grievance Policy and Procedures

The MCO must have written grievance policy and procedures whereby an enrollee who is dissatisfied with the MCO or its network may seek recourse verbally or in writing. Each MCO's internal grievance materials must be developed in a culturally sensitive manner, at a suitable reading comprehension level, and if the enrollee is a member of a substantial minority, as identified by the State, in the enrollee's native language. The MCO must provide a copy of its grievance policy and procedures to each new enrollee with the MCO's initial mailing, and at any time upon an enrollee's request.

The MCO must assure that providers are allowed to participate on behalf of the enrollee in the grievance process and that providers receive a copy of Adverse Action Letters when disputed services are reduced or denied. No punitive action will be taken against the enrollee or the provider for making a complaint against the MCO or the Department.

The timeframe in which the MCO must resolve grievances is as follows: (1) emergency medically related complaints are to be resolved within 24 hours; (2) non-emergency medically related complaints are to be resolved within 5 days; and administrative complaints are to be resolved within 30 days. Read pages 55 for information on DHMH's Complaint and Appeal Processes.

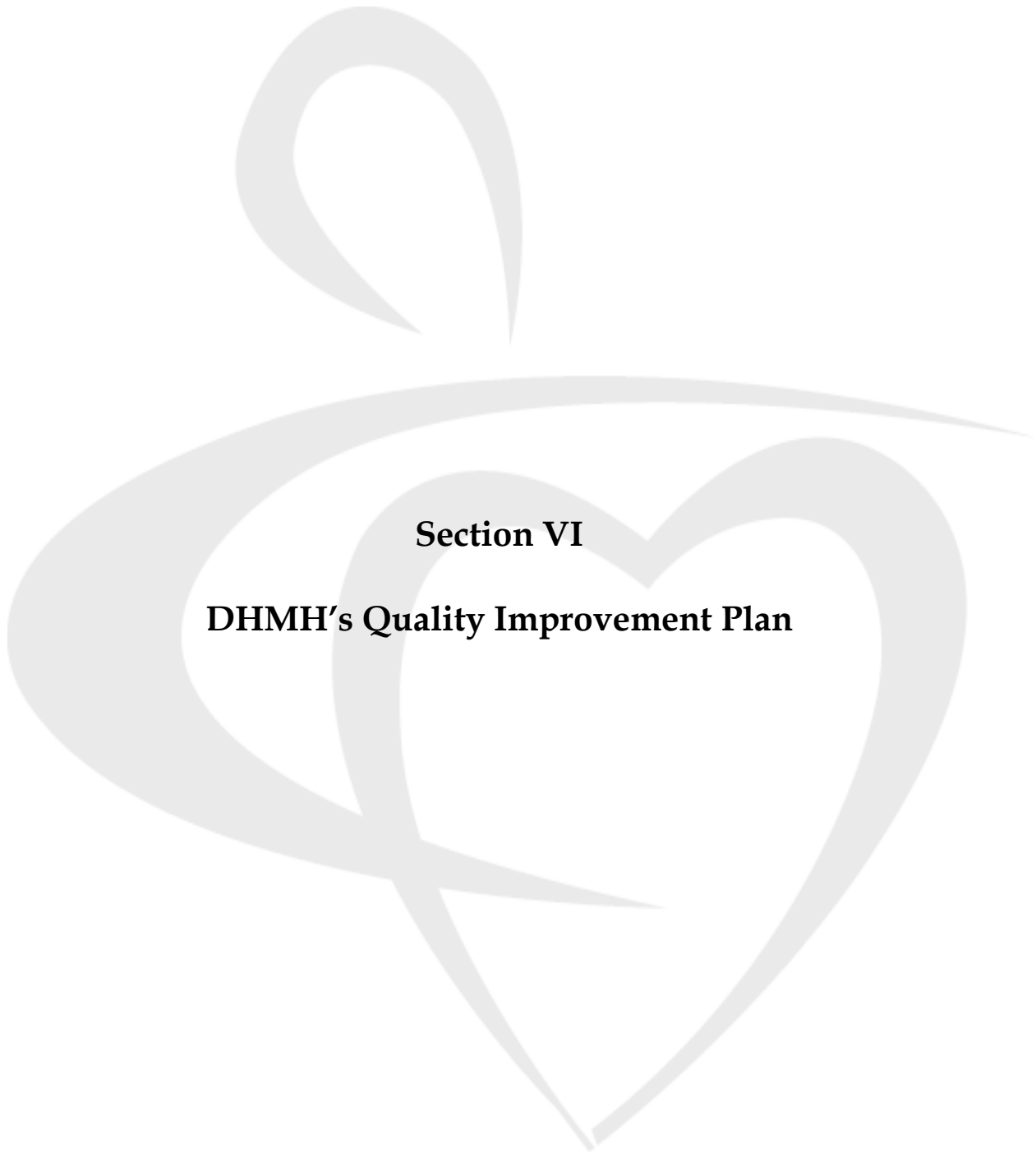
Maryland Physicians Care MCO Provider Grievance Process

Maryland Physicians Care MCO has a complaint policy and procedures for providers that are documented in writing, disseminated to all of MPC's providers at the time they join MPC's provider panel, and furnished to a provider at any time, upon request. Maryland Physicians Care MCO may not take any punitive action against a provider for utilizing the MPC provider grievance process.

Maryland Physicians Care MCO includes in its provider grievance process the following elements:

- Procedures for registering and responding to provider complaints in a timely fashion, including standards for timeliness that recognize the need for expedited determinations in situations that are time-sensitive
- Notification to the provider of an MPC's determination
- Documentation of the substance of complaints and actions taken
- Procedures for the termination or withdrawal of a provider from the MPC's provider panel

- Mechanisms to aggregate and analyze complaint and grievance data for quality improvement use
- An appeal process



Section VI

DHMH's Quality Improvement Plan

Overview of DHMH's Quality Assurance Monitoring Plan

The Department's quality assurance monitoring plan is a multifaceted strategy for assuring that the care provided to Maryland Medicaid Managed Care enrollees is of 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 Maryland Physicians Care service quality to Medicaid enrollees. These areas include:

- Health Risk Assessment/Health Needs Information screening tool which is completed by the enrollment broker at the time an enrollee selected Maryland Physicians Care to assure that Maryland Physicians Care is alerted to immediate health needs, e.g., diabetic service needs;
- A complaint system administered by Department staff;
- A complaint system administered by Maryland Physicians Care;
- The annual collection and evaluation of a set of performance measures identified by the Department; and
- Monitoring of preventive health, access and quality of care outcome measures based on encounter data;

DMHM Quality Oversight: Complaint Process

DHMH operates an Enrollee Help Line, a Provider Hotline, and a Complaint Resolution Unit. Appeals and grievances are tracked by type of source and type of complaint.

DHMH Enrollee Help Line

The Enrollee Help Line is accessible to enrollees Monday through Friday during extended business hours from 7:30 am to 5:30 pm. During other hours a message can be left and the call will be returned during the next business day. The toll free telephone number is: 1-888-754-0095 or TDD at 1-800-735-2258 for the hearing impaired.

The Enrollee Help Line is typically the enrollee's first contact with the Department. This staff handles frequently asked questions about the PAC Program. They will:

- Direct recipients to the MCO enrollee services line when needed;
- Attempt to resolve simple issues by contacting the MCO or other parties as needed; and
- Refer medical issues to the Complaint Resolution Unit for investigation, intervention and closure.

The Enrollee Help Line has the capability to address callers in languages other than English through the use of a language line service. An automated system is used by the staff to log and track enrollee and provider inquiries and complaints. Information is analyzed monthly and quarterly to determine if specific intervention with any MCO is required or changes in State policies and procedures are necessary. Intervention in individual cases is provided as necessary.

DHMH Provider Hotline

DHMH also maintains a Provider Hotline (1-800-766-8692 or TDD - 1-800-735-2258) to answer questions from providers about the PAC Program. It is staffed Monday through Friday from 8:00 am to 5:00 pm. The staff will resolve grievance from providers concerning enrollee access and quality of care issues. Maryland Physicians Care may not take any punitive action against a provider for accessing the DHMH Provider Hotline.

Provider inquiries and complaints are also tracked and analyzed monthly and quarterly to determine if specific intervention with any MCO is required or changes in State policies and procedures are necessary. Intervention in individual cases is provided as necessary.

DHMH Complaint Resolution Unit

The Complaint Resolution Unit (CRU) operates Monday through Friday from 8:00 am to 5:30 pm and has the capability to address recipients in languages other than English through the use of a language line service. This unit has a staff of registered nurses and a physician consultant who can address complex issues that require medical knowledge. Any problem that can not be readily resolved by the Enrollee Help Line or any complaint that involves a denial, reduction or termination of service or a quality of care concern, is referred to the CRU. The CRU will work with the enrollee, the provider, and Maryland Physicians Care to resolve the complaint as quickly as possible.

Departmental Dispute Resolution

When a dispute between an enrollee and Maryland Physicians Care involves the written denial of a covered benefit or service which cannot be resolved through the Department's complaint process, including its ombudsman program, the Department will either agree with the determination made by Maryland Physicians Care to deny the benefit or service or disagree with the determination of the Maryland Physicians Care to deny a benefit or service. In the case where the Department disagrees with Maryland Physicians Care determination to deny a covered benefit or service, it may order Maryland Physicians Care to provide the benefit or service immediately.

If the Department agrees with Maryland Physicians Care, the Department will issue a written notice to the enrollee within 10 business days, stating the grounds for its decision and explaining the enrollee's rights. An enrollee may only exercise their right to an appeal of a medically necessary, covered benefit. The appeal can be filed by calling 1-888-767-0013 or by completing the Request for a Fair Hearing which will be attached to the appeal letter. An enrollee has the right to speak to a lawyer at the Maryland Disability Law Center at 1-800-233-7201. Maryland Physicians Care may not discontinue, terminate, refuse to authorize or refuse to pay for a disputed benefit or service until it receives such notice from the Department.

Enrollees may exercise appeal rights pursuant to State Government Article, §10-201 et seq., Annotated Code of Maryland. Enrollees may request that a Fair Hearing be scheduled by the Office of Administrative Hearings. Maryland Physicians Care may be subpoenaed to appear as witnesses for the State at the appeal hearing.

An Administrative Law Judge will hear the case and render a decision within 90 days from the date the enrollee requested the Fair Hearing. The final decision of the Office of Administrative Hearings is appealable to the Board of Review pursuant to Health General Article §2-201 to 2-207, Annotated Code of Maryland. The enrollee will get the information on how to appeal to the Board of Review with the decision from the Office of Administrative Hearings. If the Board of Review decides against the enrollee they may appeal to the Circuit Court pursuant to State Government Article §10-201 et seq., Annotated Code of Maryland.



Section VII

Forms and Attachments