



# **Primary Adult Care (PAC) Program Provider Manual**

**January 2008**

# **Introduction to the PAC Provider Manual**

---

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

Since January 2006, individuals who previously received Pharmacy Assistance from the State but also have Medicare coverage have been enrolled in the Medicare Part D Prescription Drug Program. Beginning July 1, 2006, the remaining Maryland Pharmacy Assistance recipients who do not have Medicare will transition to the new Primary Adult Care (PAC) Program. In addition to prescription drug coverage, the new PAC Program provides primary care benefits and coverage for mental health services. When fully implemented, PAC is expected to serve approximately 30,000 low-income individuals.

Much like HealthChoice, DHMH has contracted with Managed Care Organizations (MCOs) to provide primary care and pharmacy benefits to PAC members. PAC members must choose an MCO or they will be assigned to one. The State will pay the MCO a capitated rate. MCOs then contract (either fee-for-service or capitation) with primary care providers. MCOs are required to provide some additional services for individuals who have diabetes. Otherwise the PAC benefit does not include specialty care, inpatient and outpatient hospital and emergency room services. Read pages 43 - 45 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 individual MCOs which are not addressed in this Manual must be directed to Maryland Physicians Care MCO Provider Relations 1-800-953-8854.

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 the Primary Adult Care (PAC) Program including, but not limited to, program eligibility and some general information on MPC credentialing and reimbursement policies.

## **Section II. Provider Responsibilities**

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

## **Section III. PAC Benefits and Services**

This section provides a listing of the PAC benefits. This includes benefits that are the responsibility of MPC. This section also identifies benefit limitations and services that are not the responsibility of MPC 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. These services are known as specialty mental health services.

**Section V. Member Information**

This section addresses Member Rights and Responsibilities, the MPC Complaint, Grievance and Appeal Process, and describes procedures for Members to select and change PCPs.

**Section VI. DHMH Quality Improvement Program**

This section reviews DHMH's quality improvement activities for the PAC Program. This also includes information on DHMH Complaint and Appeal Processes.

**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.

# Table of Contents

## I. Key Facts for Providers

The Primary Adult Care Program	1
Eligibility for PAC	1
Credentialing and the Role of the PCP	1
Provider Reimbursement	4
PCP Contract Terminations	5
Continuity of Care	5
Specialty Referrals	6
Attachment I-A -- Statement of Needed Service Form	7
Attachment I-B -- Medical Record Standards for Primary Care Providers	8

## II. Provider Responsibilities

Appointment Scheduling and Outreach Requirements	11
• General Requirements for an Initial Health Visit	11
• Individuals with HIV/AIDS	11
• Individuals with Disabilities	11
• Individuals in Need of Alcohol and Substance Abuse Treatment	12
• Pregnancy-Related Services	12
Support Services	12
Submitting Claims & Encounter Data Reporting Requirements	12
Reporting Communicable Disease	18
Attachment II-A -- List of Communicable Diseases	19

## III. PAC Benefits and Services

Overview	22
Covered Benefits and Services	23
• Dental Care Services	23
• Diabetes Care Services	23
• Diagnostic Radiology Services	24
• Electrocardiogram Testing	24
• Family Planning and Gynecological Services	24
• Formulary Requirements	24
• Laboratory Services	25
• Non-Prescription Drugs	25
• Pharmacy Services	25
• Pharmacy Limitations	25
• Pharmacy Formulary Requirements	26
• Podiatry Services	26
• Primary Care Services	26
• Primary Mental Health Services	27
• Self-Referral Services	27

• Services that Require Prior Authorization	27
• Vision Care Services	28
• Non-Covered Services	28
<b>IV. Specialty Mental Health Services</b>	
Overview of Specialty Mental Health Services	29
Access to Specialty Mental Health Services	29
Referring Members to the Public Mental Health System	30
Specialty Mental Health Services Limitations	30
Attachment IV-A - Mental Health Diagnoses Covered by Maryland Physicians Care	31
<b>V. Member Information</b>	
Member Rights and Responsibilities	32
Americans with Disabilities Act	33
Communication Access	33
Cultural Competency	33
Procedure for Selecting a PCP	33
Procedure for Changing PCPs	34
Maryland Physicians Care Complaint, Grievance and Appeal Processes	34
<b>VI. DHMH's Quality Improvement Plan</b>	
Overview of Quality Assurance Monitoring Plan	36
DHMH Quality Oversight and Complaint and Appeal Processes	36
• Enrollee Action Line	36
• Provider Hotline	37
• Complaint Resolution Unit	37
• Ombudsman/Administrative Care Coordination Program	37
• Departmental Dispute Resolution	38
<b>VII. Forms and Attachments</b>	
Appendix A -- Important Phone Numbers	39
Appendix B -- Referral Resource Directory	40
Appendix C -- EPSDT Periodicity Schedule	42
Appendix D -- Preventive Screenings	44
Appendix E -- Laboratory, Radiology & DME Codes	45



## **Section I**

# **Key Facts for Providers**

## **The Primary Adult Care Program (PAC)**

---

The Maryland Primary Care (PAC) Program serves very low-income individuals who are not eligible for Medicare. When the program began on July 1, 2006, individuals who had previously been in the Pharmacy Assistance Program were enrolled in the new 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 Managed Care Organizations (MCOs) to keep their prescription drug coverage and to get the additional primary care services.

## **PAC Eligibility**

---

The eligibility for PAC is based on the same income and asset limits as the previous Maryland Pharmacy Assistance Program. Income for individuals must be less than 116% of the federal poverty level and their assets can be no more than \$4,000. Individuals must be age 19 or older and not dependent. Since individuals with Medicare now qualify for prescription drug coverage under Medicare Part D, PAC requires that individuals age 65 and over provide proof that they are not eligible for Medicare. Recipients must re-apply for PAC annually. For eligibility related questions, call 1-800-226-2142.

## **Provider Credentialing and Role of the PCP (Only if the provider is new to MPC)**

---

### **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 (MPC) MCO Provider Reimbursement**

Payment to individual Providers is in accordance with their contracts with Maryland Physicians Care MCO or with your management group that contracts on their behalf with Maryland Physicians Care MCO. 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 providers with Maryland Physicians Care MCO] will be entirely a function of the specific terms of the individual contract with Maryland Physicians Care MCO.

### **Eligibility Verification System**

Prior to rendering services, call 1-800-953-8852 or the Medicaid Eligibility Verification System (EVS) at 1-800-492-2134 to check the Member's eligibility and their MCO enrollment status. You must bill the MCO which is indicated on the EVS message. A PAC Member must be enrolled in Maryland Physicians Care MCO on the date of service in order for Maryland Physicians Care MCO to pay for primary care services. Primary care services are only covered when a PAC member 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 Members 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 MCO requires that Providers bill the other insurance first.

If there is third-party coverage for a member including, but not limited to, Medicare Part A or Part B, the provider agrees to identify and seek payment from any third party obligated to pay for Member's health care services before submitting claims. MPC is a secondary payer to all other parties.

When submitting a claim or encounter data for covered services, the provider shall include a complete copy of the Explanation of Benefits (EOB) or Remittance Advice (RA) for the other coverage. The claim shall be for MPC's reimbursement as secondary payer of last resort. The claim and associated primary payer Explanation of Benefits statement (EOB) or remittance advice (RA) must be initially received by MPC within twelve (12) months of the date of service as set forth in the Timely Filing Limitations (below) of this manual.

### **Timely Payment**

In accordance with the Maryland Annotated Code, Health General Article §15-1005, Maryland Physicians Care MCO 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 MCO will pay a Provider for covered services within 30 days after receipt of all reasonable and necessary documentation. Maryland Physicians Care MCO 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 delivered in hospitals, including outpatient, inpatient and emergency room settings.** However, should Maryland Physicians Care MCO contract with a provider that is usually paid Health Services Cost Review Commission (HSCRC) rates, Maryland Physicians Care MCO 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 for more information on Family Planning services covered under PAC. If you have questions, call the Medicaid Family Planning Program at 1-800-456-8900.

### **Reimbursement of Providers for Services Under Appeal**

If Maryland Physicians Care MCO denies, reduces or terminates a covered service, PAC members have an appeal right, regardless of whether they are a new or an established enrollee. Pending the outcome of an appeal, Maryland Physicians Care MCO must reimburse Providers for the services. PAC members do not have appeal rights for non-covered services.

### **Provider/PCP Contract Termination**

---

If a Provider contract with Maryland Physicians Care MCO is terminated, the PAC members assigned to the PCP may elect to change to another MCO in which the Provider participates by calling the Enrollment Broker at 1-866-676-5880 within 90 days of the Provider contract termination.

The reason for the termination must be one of the following:

- Maryland Physicians Care MCOs reduction of the PCP's capitated rate/applicable fee-for-service to the extent that the reduction in rate is greater than the actual change in capitation paid to Maryland Physicians Care MCO by the Department and the Provider and Maryland Physicians Care MCO are unable to negotiate a mutually acceptable rate
- The MCO terminates the contract for reasons other than quality of care or the PCP's failure to comply with contractual requirements related to quality assurance activities
- Maryland Physicians Care MCO terminates its contract with the State
- Maryland Physicians Care MCO is acquired by another entity

If the contract termination was for quality of care issues, or the PCP's failure to comply with contractual requirements related to quality assurance activities, enrollees do not have the option of changing MCOs.

### **Continuity of Care**

---

Maryland Physicians Care MCO 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 MCO completes an initial evaluation of the Member and develops a new plan of care. This provision does not apply to any non-covered services the Member is receiving at the time of enrollment in Maryland Physicians Care MCO.

If Maryland Physicians Care MCO determines that a reduction in a covered service is warranted, Maryland Physicians Care MCO must notify the Member of this change at least 10 days before it is implemented. This notification must inform the Member that he/she has the right to formally complain to the Department by calling the Enrollee Action Line at 1-888-754-0095. In addition, the notice must also explain that if the Member files the complaint within ten days of the Maryland Physicians Care MCO notification, then Maryland Physicians Care MCO 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 action:

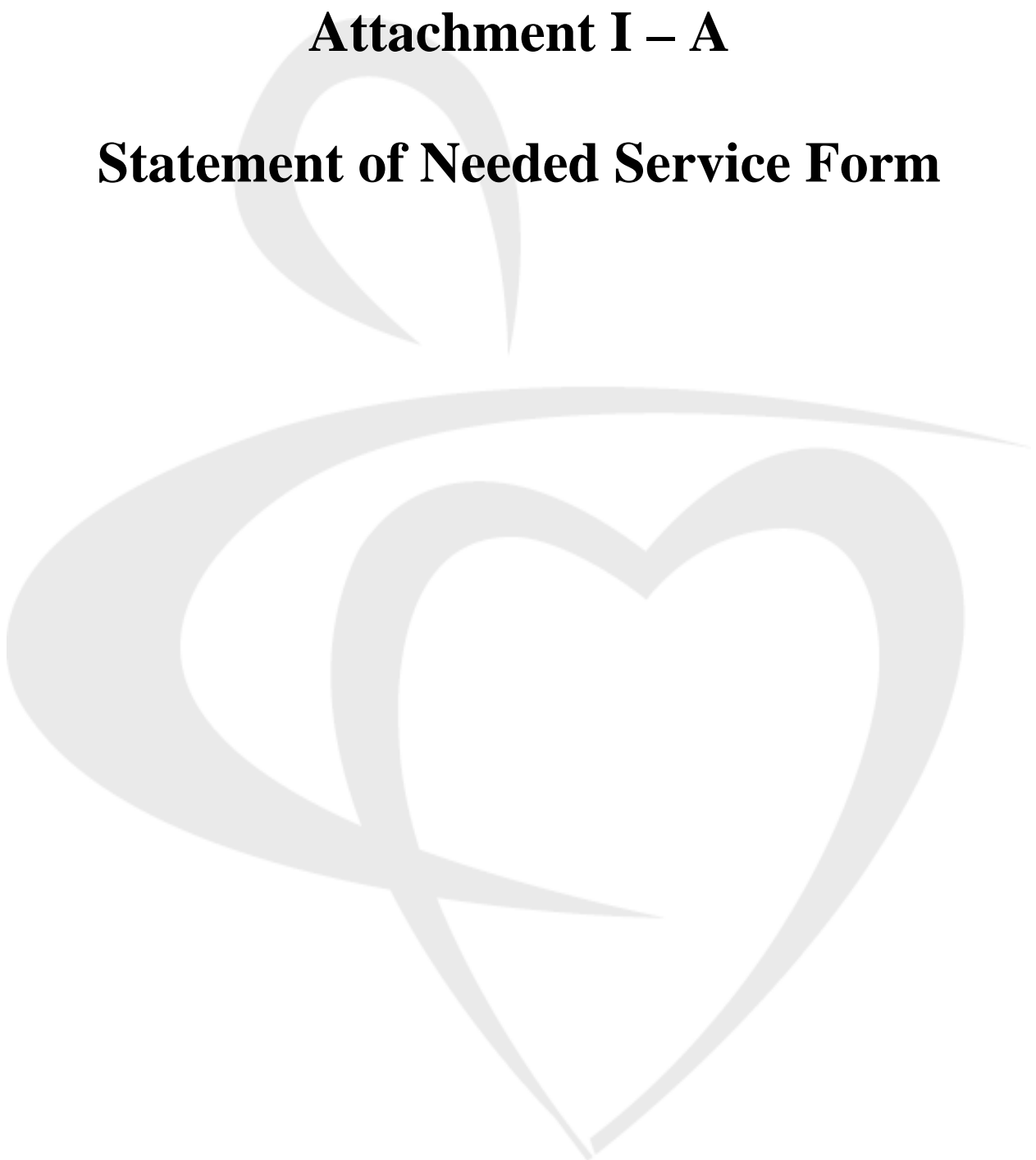
- 1) Refer the Member to an appropriate provider of the service
- 2) Indicate to the specialty provider that the Member does not have medical coverage for the referred services
- 3) Clearly inform the Member that the service is not covered by PAC and that the Member will be financially responsible for the services
- 4) Provide the Member with a completed Statement of Needed Service Form  
(See Attachment I-A)

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 MCO is not required to arrange or coordinate specialty care, Maryland Physicians Care MCO may assist PAC members in locating a specialist. If the Member needs additional help in locating a specialty provider, the Member can also call the State's Enrollee Action Line at 1-888-754-0095. Staff will attempt to identify a resource (e.g., FQHC, hospital) for the Member.



**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.***

<b><i>Date of Referral:</i></b>	
<b>1. Patient Information</b>	
Name (Last, First, MI):	
Date of Birth (MM/DD/YY):	MA ID#
MCO:	
<b>2. Primary Care Provider</b>	
Name (Last, First, MI):	
Institution/Group Name:	
Address (Street, City, State, Zip):	
Phone Number: (    )	
<b>3. Specialty/Facility Provider</b>	
Name (Last, First, MI):	Specialty:
Institution/Group Name:	
Address (Street, City, State, Zip):	
Phone Number: (    )	Fax Number: (    )
<b>4. Referral Information:</b>	
Reason for Referral:	
Brief History, Diagnosis and Test Results:	
<b><i>Patient Responsibility Acknowledgement:</i></b>	
I understand that the services on this Statement of Needed Service form <b>are not covered by the PAC Program</b> 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*** --
  - o For all adult members age 21 and older, records must indicate patient's immunization status for Td
  - o For members age 65 and older, record must indicate immunization status for influenza and pneumococcal
  - o 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
  - o 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



## **Section II**

# **Provider Responsibilities**

## **Appointment Scheduling and Outreach Requirements**

---

Prior to seeing a PAC Member, Providers must call Maryland Physicians Care MCO Member Services at 1-800-953-8852 or EVS # 1-800-492-2134 to verify recipient eligibility and MCO enrollment. This step is essential to assure payment for services rendered.

### **Initial Health Appointment for PAC Members**

In general, PAC Members 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 Member already has an established relationship with the Provider.
- As part of the enrollment process the State completes a Health Needs Information form to determine if the Member 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 Members who are 19 or 20 years old. The State received approval from CMS to waive federal EPSTD requirements for the PAC Program. Therefore PAC members 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 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 must be accessed through sites that receive federal and state Ryan White grant funds. HIV/AIDS drugs will be covered by the Member's PAC (yellow and white) ID card. Maryland Physicians Care MCO 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, call the AIDS Hotline at 1-800-638-6252.

### **Individuals with Disabilities**

Maryland Physicians Care MCO is responsible for accommodating physical access to covered services and for accommodating hearing-impaired enrollees who require and request a qualified interpreter.

Maryland Physicians Care MCO triage, member services and case management staff have received training on the special communications requirements of individuals with physical disabilities. Maryland Physicians Care MCO 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 in which Members can understand the material, whether on paper or by voice translation.

Unlike Health Choice, PAC does not require Maryland Physicians Care MCO to provide case management services. Local health departments **are not required** to accept referrals for care coordination for PAC Members. 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 Members on a case-by-case basis. Read Appendix B for list of agency phone numbers.

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

The PCP is responsible for performing a substance abuse screen as part of the Member's initial health appraisal and periodically as needed and for referring Members for substance abuse treatment whenever it is indicated. Inform PAC Members that alcohol and substance abuse treatment is not a covered benefit under PAC. (Buprenorphine is covered under the pharmacy benefit.) Substance abuse services are available on a sliding fee basis. For assistance in locating local treatment programs call the State's Alcohol and Drug Abuse Administration Referral Line at 1-410-402-8600.

## **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 Members who become pregnant to the local health department MCHP Eligibility Unit or the MCHP Information Line at 1-800-456-8900. Once a Member has MCHP coverage she will be enrolled in a HealthChoice MCO. If the PCP participates in both PAC and HealthChoice, the Member will not need to change her PCP or MCO if the member indicates at enrollment that they want to stay with their existing MCO (Maryland Physicians Care MCO).

## **MCO Support Services**

---

All important phone numbers and addresses for Maryland Physicians Care MCO Support Services are located under Section VII, Appendix A (Forms & Attachments).

## **Submitting Claims & Encounter Data Reporting Requirements**

---

Maryland Physicians Care MCO is required to submit encounter data monthly, which reflects 100% of provider-enrollee encounters in either the CMS 1500 or **UB04** format. This data is required to be reported within 60 calendar days after the receipt of the claim.

Providers shall utilize the most current diagnostic and procedure coding guidelines, including but not limited to, International Classification of Diseases (ICD), American Medical Association Current Procedural Terminology (AMA CPT), Health Care Financing Administration Common Procedural Coding System (HCPCS), Diagnostic Statistical Manual (DSM), Current Dental Terminology (CDT), and Uniform Billing Data Elements (**UB04**) Specification Manual.

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 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*.

### **Acceptable Claim Forms**

All claims for professional services must be submitted on a CMS 1500 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.**

## **Claims Appeals**

A provider disputing a claim denial may formally request a review of the decision by submitting a request in writing to MPC within ninety (90) working days of MPC’s decision. The written request must include the following supporting documentation:

- Nature of the request
- Member’s name, date of birth, plan ID#
- Service/admission date
- Location of the treatment, service or procedure
- Documentation supporting the request
- Copy of the claim
- Copy of the original denial (Remittance Advice or Denial Letter)

Upon receipt of the request, the request will be forwarded to the MPC Grievance and Appeals Committee or a representative of MPC who was not involved in the initial decision for review.

An appeal decision is rendered within thirty (30) working days after the filing date. The Grievance and Appeals Unit will send a written notice of the appeal decision to the provider who filed the appeal within thirty (30) calendar days of the date of the decision.

### 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).

<b>CMS 1500 Form:</b>		
<b>Field Number</b>	<b>Field Title</b>	<b>Field Description</b>
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.

<b>CMS 1500 Form:</b>		
<b>Field Number</b>	<b>Field Title</b>	<b>Field Description</b>
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.
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.
<b>ITEM 17b</b>	<b>NPI NUMBER OF REFERRING PHYSICIAN</b>	<b>This is the NPI number of the referring physician.</b>
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.

<b>CMS 1500 Form:</b>		
<b>Field Number</b>	<b>Field Title</b>	<b>Field Description</b>
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.)
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	<b>HEALTHCHOICE NUMBER</b>	<b>The HealthChoice Provider ID Number</b>
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.
<b>ITEM 32a</b>	<b>NPI NUMBER OF PROVIDER IN ITEM 32</b>	<b>Service Location</b>
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.
<b>ITEM 33a</b>	<b>GROUP NPI NUMBER</b>	<b>The Pay-To NPI Number for the group</b>
<b>ITEM 33b</b>	<b>GROUP HEALTHCHOICE NUMBER</b>	<b>The HealthChoice Number for the group (If applicable)</b>

## 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

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 and demographics on the enrollee including the name age, race, sex and address of residence, hospitalization, date of death, etc. on a form provided by the Department (DHMH1140) as directed by COMAR 10.06.01.
- 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. A list of laboratory reportable diseases is included in Attachment II A.

***In cases of laboratory reporting of HIV and CD4+ counts less than 20C/mm3, reports must not identify the enrollee by name, but must report the individual using a unique patient identifying number instead (See COMAR 10.18.02.01).***

Laboratories that perform micro-bacteriology 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 MCO cooperates with local health departments in investigations and control measures for communicable diseases and outbreaks.



## **Attachment II-A**

### **List of Communicable Diseases**

**The diseases or conditions reportable by a medical laboratory director are:**

---

- (1) Amoebiasis
- (2) Anthrax
- (3) Arbovirus infection (all types)
- (4) Bacteremia in newborns
- (5) Botulism
- (6) Brucellosis
- (7) Campylobacter infection
- (8) CD 4+ count, if less than 200/MM<sup>3</sup>
- (9) Chlamydia infection
- (10) Cholera
- (11) Coccidioidomycosis
- (12) Creutzfeldt-Jakob Disease
- (13) Cryptosporidiosis
- (14) Cyclosporiasis
- (15) Dengue fever
- (16) Diphtheria
- (17) Ehrlichiosis
- (18) Encephalitis, infectious
- (19) E. Coli 0157:H7 infection
- (20) Giardiasis
- (21) Gonorrhea
- (22) Haemophilus influenzae, invasive disease
- (23) Hansen disease (leprosy)
- (24) Hantavirus infection
- (25) Hepatitis, viral, types A, B, C, and other types
- (26) Human immunodeficiency virus infection
- (27) Isosporiasis

- (28) Legionellosis
- (29) Leptospirosis
- (30) Listeriosis
- (31) Lyme disease
- (32) Malaria
- (33) Measles
- (34) Meningococcal invasive disease
- (35) Meningitis, infectious
- (36) Microsporidiosis
- (37) Mumps
- (38) Pertussis
- (39) Pesticide related illness
- (40) Plague
- (41) Poliomyelitis
- (42) Psittacosis
- (43) Q fever
- (44) Rabies
- (45) Ricin toxin
- (46) Rocky Mountain spotted fever
- (47) Rubella and congenital rubella syndrome
- (48) Salmonellosis (nontyphoid fever types)
- (49) Severe acute respiratory syndrome
- (50) Shiga-like toxin production
- (51) Shigellosis
- (52) Smallpox and other orthopox viruses
- (53) Staphylococcal enterotoxin
- (54) Streptococcal invasive disease, group A
- (55) Streptococcal invasive disease, group B
- (56) Streptococcus pneumoniae, invasive disease

- (57) Syphilis
- (58) Trichinosis
- (59) Tuberculosis
- (60) Tularemia
- (61) Typhoid fever
- (62) Varicella (chickenpox), fatal cases only
- (63) Vibriosis, noncholera
- (64) Viral hemorrhagic fevers (all types)
- (65) Yellow fever
- (66) Yersiniosis



## **Section III**

# **PAC Benefits and Services**

## Overview of Benefits

---

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

- Prior to MCO enrollment, PAC Members get their prescription drugs and mental health services using their yellow and white Medicaid fee-for-service card.
- After the Member is enrolled in Maryland Physicians Care MCO, prescription drugs, except most mental health drugs and HIV/AIDS drugs, will be the responsibility of Maryland Physicians Care MCO.
- After the Member is enrolled in Maryland Physicians Care MCO, certain mental health drugs which have multiple uses will be the responsibility of Maryland Physicians Care MCO.
- Coverage for primary care and certain services for PAC Members with diabetes begin once the Member is enrolled in Maryland Physicians Care MCO.
- Specialty care, in-patient and outpatient hospital and emergency room services are **not covered** for PAC Members by either the State or by Maryland Physicians Care MCO.
- After Maryland Physicians Care MCO enrollment, primary mental health services will be the responsibility of Maryland Physicians Care MCO if services are performed by the member's PCP.
- The PCP must bill Maryland Physicians Care MCO for primary care services. State Medicaid does not pay claims from PCPs or reimburse PCPs for services to PAC Members.
- The PCP serves as the entry point for access to health care services. The PCP is responsible for providing PAC Members 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 Member.
- Benefits and services are covered only if medically necessary.
- PAC members have the right to access family planning services without any prior referral or authorization by the PCP. Maryland Physicians Care MCO is responsible for reimbursing out-of-plan providers who have furnished these services.
- PAC Members have coverage for routine Gynecological services. If the PCP does not perform GYN exams, Maryland Physicians Care MCO will arrange for the service through another network provider.
- PAC Members may not be charged any copayments, premiums or cost sharing of any kind, except when specifically allowed by law.
- Maryland Physicians Care MCO charges PAC enrollments \$2.50 copayment for generic drugs and \$7.50 copayment for brand name drugs.

- Maryland Physicians Care MCO cannot restrict access to needed drugs and related pharmaceutical products by requiring PAC Members to use mail order pharmacy services.
- If a PAC Member does not pay the copay assessed by Maryland Physicians Care MCO, the pharmacist may refuse to fill the prescription. (Note: This policy differs from HealthChoice and regular Medicaid).
- Maryland Physicians Care MCO does not charge pharmacy copayments during pregnancy or for family planning drugs or 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, Doral Dental USA which may be contacted at (800) 936-0935. Please contact Doral Dental USA or access MPC's website at [www.MarylandPhysiciansCare.com](http://www.MarylandPhysiciansCare.com) for addition information regarding this value added benefit.***

### **Diabetes Care Services**

Maryland Physicians Care MCO covers the following diabetes care services for Members 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
  - Diagnostic reagent strips and tablets used for testing for ketone and glucose in urine and glucose in blood
- Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear

DME and/or DMS must be provided in a timely manner so as not to adversely affect the Member's health. Any preauthorization required by the MCO is required to be completed within 72 hours.

## **Diagnostic Radiology Services**

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

## **Family Planning Services and Gynecological Services**

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

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

## **Laboratory Services**

Maryland Physicians Care MCO 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
- 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

## **Non-Prescription Drugs**

Maryland Physicians Care covers several over-the-counter drugs. To find out which medications are available, you can visit [www.MarylandPhysiciansCare.com](http://www.MarylandPhysiciansCare.com) or call MPC's Provider Services Department at 1-800-953-8854.

## **Pharmacy Services**

Maryland Physicians Care MCO 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 MCO are listed at [www.MarylandPhysiciansCare.com](http://www.MarylandPhysiciansCare.com)
- HIV/AIDS drugs are not covered by Maryland Physicians Care MCO but are covered by the State
- Iron for anemia
- Ferrous Sulfate

## **Pharmacy Limitations**

Neither the State nor Maryland Physicians Care MCO 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

## Pharmacy - Formulary Requirements

- Maryland Physicians Care MCO is required to expand the drug formulary to include new products approved by the Food and Drug Administration (FDA). In addition, Maryland Physicians Care MCO maintains 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 MCO or its designee, a decision will be made within 72 hours after the initial request. If the service is denied, Maryland Physicians Care MCO will notify the prescriber and the Member in writing of the denial.
- *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.*

## Podiatry Services

Podiatry services are only covered for PAC Members with diabetes. Covered podiatry services include special shoes, non-custom inserts and supports and routine foot care. Routine foot care may be limited to one visit every 60 days.

## Primary Care Services

Primary care encompasses care which is generally received by the Member'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 Member 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
- 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 MCO will pay for the service. However, for routine gynecological services, Maryland

Physicians Care MCO requires that the member 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 MCO 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 Member, regardless of the diagnosis and severity of illness, if the treatment falls within the scope of the PCP's practice, training and expertise. Neither the PCP nor Maryland Physicians Care MCO may bill the Public Mental Health System (PMHS) for the provision of such services. These services are included in Maryland Physicians Care MCO rates.
- When, in the PCP's judgment, a PAC Member 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

## **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](http://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 MCO
- Abortions (including medical abortions) and fertility treatments
- Diet and exercise programs for the loss of weight
- Immunizations for travel outside the U.S.

## Examples of Non-Covered Services

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

- Alcohol and Drug treatment, except buprenorphine
- Audiology and Hearing Aids
- Blood and Blood products
- Case Management
- Dental care, including general and emergency, and orthodontia service
- Diet, exercise and weight reduction programs
- Hospice care
- Hospital services (inpatient and outpatient) and emergency care
- Nursing Home/Long-term care facility
- Oxygen and Respiratory Equipment
- Personal care, Home Health, Private Duty Nursing and Medical Day Care
- Pregnancy-related services (Note: PAC members 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
- 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 Members must access 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 ASO. The ASO provides administrative management functions for all CSAs statewide.

After a PAC Member is enrolled in an MCO, the PMHS is only responsible for specialty mental health services. Primary Mental Health Services are the responsibility of Maryland Physicians Care MCO. Read page 26 for more information on Primary Mental Health services. Specialty Mental Health Services (SMHS) are discussed below.

## **Access to Specialty Mental Health Services**

---

- Specialty Mental Health Services (i.e., any mental health services other than primary mental health services) are not subject to capitation and are not Maryland Physicians Care MCO responsibility with regard to payment. However, Maryland Physicians Care MCO and/or the PCP does have the responsibility to refer appropriately eligible Members to the Public Mental Health System when specialty mental health services are needed.
- A Member with a probable diagnosis of a mental disorder is eligible for referral to the PMHS by the PCP or Maryland Physicians Care MCO if the following conditions are met:
  - The Member'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 Attachment IV-A on page 31
  - The PCP or Maryland Physicians Care MCO 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 are cost-effective.
- If the SMHS UR agent determines that there is medical necessity for specialty mental health services, the Member 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 necessary, promptly consult MPC and (if involved) the PCP or other provider, for assistance in developing a plan for the Member, to determine whether an alternative service or a service of alternate duration is appropriate.
- If the SMHS UR agent denies services, the Member or the PCP will be notified orally or in writing, specifying the clinical rationale for the denial and outlining procedures for contesting 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 Member's living situation or cause severe disruption to a Member with serious and persistent mental illness or serious emotional disturbance.

## **Referring Members 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 masters prepared mental health clinicians called Care Managers. Care Managers are licensed mental health professionals in accordance with Maryland's Health Occupation Act.

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

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

- **Acute Crisis-** A situation in which a Member is threatening imminent harm to self or another. The Member or the person making the call may state or imply that the Member 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 a Member (or the person making the call) who states or implies that the Member may do harm to self or another person if help is not received soon. The Member (or person calling) states or implies the Member'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 Member 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 Member 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 Member or caller feels that the Member is in no immediate harm, but requires an assessment and probable mental health services. The PMHS system's protocols require that Members 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 Members 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 Members 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.



## **Attachment IV-A**

# **Mental Health Diagnoses Covered By Maryland Physicians Care MCO**

## Mental Health Diagnoses Covered By Maryland Physicians Care MCO

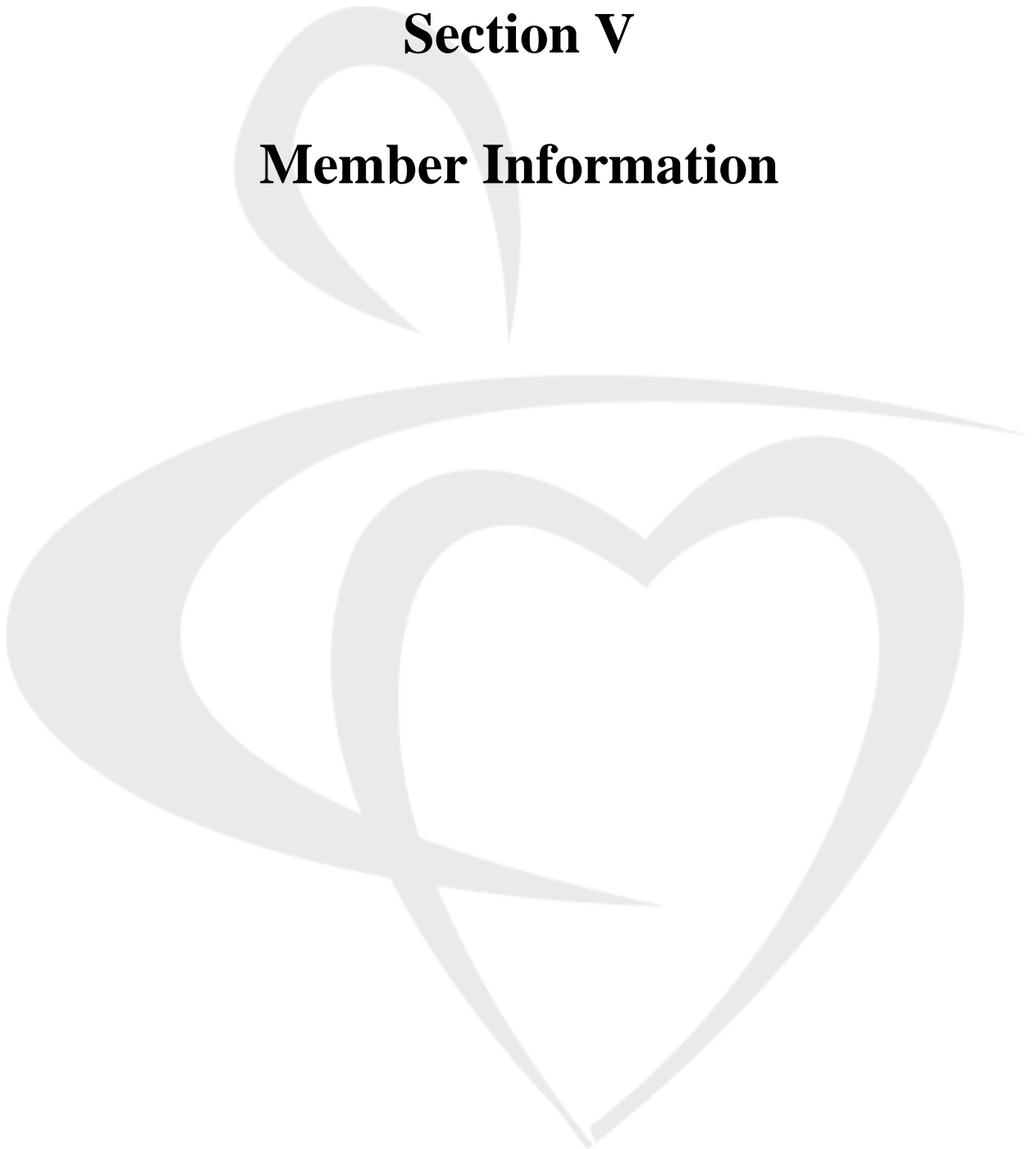
---

ICD-9CM Code	Description
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**

# **Member Information**



## **Member 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.

### **Members 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.

### **Members 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 1-800-953-8852.

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 MPC's 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 36 - 38 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 recipients 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 MCO 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 a Member selected Maryland Physicians Care MCO to assure that Maryland Physicians Care MCO is alerted to immediate health needs, e.g., diabetic service needs
- A complaint, grievance and appeals system administered by Department staff
- A complaint, grievance and appeals system administered by Maryland Physicians Care MCO
- The annual collection and evaluation of a set of performance measures identified by the Department
- Monitoring of preventive health, access and quality of care outcome measures based on encounter data

## **DMHM Quality Oversight: Complaint and Appeal Processes**

---

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

### **DHMH Enrollee Action Line**

The Enrollee Action Line is accessible to Members 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 Action Line is typically the Member's first contact with the Department. This staff handles frequently asked questions about the PAC Program. They will:

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

The Enrollee Action 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 Member 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 individualized cases is undertaken 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 complaints from providers concerning Member access and quality of care issues. Maryland Physicians Care MCO 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 individualized cases is undertaken 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 cannot be readily resolved by the Enrollee Action Line or any complaint that involves a denial, reduction or termination of service or a quality of care concern, is referred to CRU. The Complaint Resolution Unit will work with the Member, the Provider and Maryland Physicians Care MCO to resolve the complaint as quickly as possible. When necessary, a referral will be made to the local health department Ombudsman/ACCU Program.

## **Ombudsman/Administrative Care Coordination Unit (ACCU) Program**

The Department operates an Ombudsman/ACCU Program for the purpose of investigating disputes between Members and Maryland Physicians Care MCO. The Complaint Resolution Unit initiates referrals to the local ombudsman when indicated. The local health departments are required to have ombudsman staff who have medical knowledge and suitable experience and training to address complex issues.

The primary role of the ombudsman/ACCU is to educate enrollees about the services provided by Maryland Physicians Care MCO and their rights and responsibilities in receiving services from Maryland Physicians Care MCO. The ombudsman/ACCU Programs have the ability to visit the Member's home and community. This provides the Department with additional information from the Member's perspective to utilize to resolve the complaint and prevent complaints in the future. The local ombudsman does not have authority to compel Maryland Physicians Care MCO to provide disputed services or benefits.

When the local ombudsman receives a complaint from the Department's Complaint Resolution Unit, the local ombudsman may take any or all of the following actions, as appropriate:

- Attempt to resolve the dispute by educating the Member
- Utilize mediation or other dispute resolution techniques
- Assist the Member in negotiating Maryland Physicians Care MCO internal grievance process
- Advocate on behalf of the Member throughout the MCO internal grievance and appeals process

Feedback from the ombudsman/ACCU, including details relating to the case and an explanation of how the case was resolved, must be provided to the Complaint Resolution Unit within the timeframe specified.

## **Departmental Dispute Resolution**

When a dispute between a Member and Maryland Physicians Care MCO 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 MCO to deny the benefit or service, or disagree with the determination of the Maryland Physicians Care MCO to deny a benefit or service. In the case where the Department disagrees with Maryland Physicians Care MCO determination to deny a covered benefit or service, it may order Maryland Physicians Care MCO to provide the benefit or service immediately.

If the Department agrees with Maryland Physicians Care MCO, the Department will issue a written notice to the Member within 10 business days, stating the grounds for its decision and explaining the Member's rights. A Member 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. They have a right to speak to a lawyer at the Maryland Disability Law Center at 1-800-870-6362. Maryland Physicians Care MCO 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.

Members may exercise appeal rights pursuant to State Government Article, §10-201 et seq., Annotated Code of Maryland. Members may request that a Fair Hearing be scheduled by the Office of Administrative Hearings. Maryland Physicians Care MCO 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 Member 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 Member 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 Member 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**



## **Appendix A**

# **Important Phone Numbers**

## Important Phone Numbers and Addresses

---

The MPC organization is located in Baltimore with a satellite office in Cumberland. To assist providers in reaching the appropriate MPC staff, the following list of important telephone numbers is provided.

<i>MPC Baltimore 509 Progress Drive, Suite 117 Linthicum, MD 21090</i>	1-800-953-8854 1-410-401-9400 1-410-609-9013(fax)
<i>Western Maryland Regional Office 13700 McMullen Hwy SW, Suite 1 Cumberland, MD 21502</i>	1-800-953-8854 option 2, option 3 1-240-362-0169 (fax)
<i>Member Services (24 hours, 7 days a week)</i>	1-800-953-8854 , option 1 1-410-401-9015 (fax)
<i>Provider Relations</i>	1-800-953-8854 option 2, option 3 1-410-609-9013 (fax)
<i>Provider Relations (Western MD) Garrett, Allegany, Washington Counties</i>	410-401-9507 1-240-362-0169 (fax)
<i>Prior Authorization (24 hours, 7 days a week)</i>	1-800-953-8854, option 2 1-800-953-8856 (fax)
<i>Administrative Offices</i>	1-800-953-8854 1-410-277-9710 1-410-277-9722 (fax)
<i>Claims Inquiry</i>	1-800-953-8854 option 2, option 2
<b>Claims Mailing Address:</b>	
Maryland Physicians Care Attn: Claims Department P. O. Box 61778 Phoenix, AZ 85082-1778	
<b>Grievance/ Appeals Mailing Address:</b>	
Maryland Physicians Care Attn: Appeals Department 509 Progress Drive, Suite 117 Linthicum, MD 21090	



# **Appendix B**

## **Referral Resource Directory**

<b>Services Offered</b>	<b>Group Name</b>	<b>Phone</b>
Adult Literacy Program/GED Preparation	The Learning Bank	(410) 659-5452
Advocacy, Residential, Respite Care, Community Education	Charles County HARC	(301) 932-7030
African American Educational Aids	Black Educational Aids Project Inc.	(410) 889-8822
C.C.(Care Connection)-liaison link between physicians/patients	Care Connection	(410) 519-1209
Case Mgmt for DD (Developmental Disability), advocacy	ARC/Service Coordination	(410) 235-8110
Children's Services	Little People Therapeutic Project	(410) 435-3705
Children's Services	The Coordinating Center for Home & Community Care	(410) 987-1048
Children's Services-Child Abuse Ctr.	Child Abuse Prevention Center of MD.	(410) 576-2414 x15
Children's Services-Child Welfare Organization, ages 0-17	Casey Family Services	(410) 342-7554
Children's Services-Day Care homes, gives parents listings of state approved	Locate Child Care	(410) 625-1111
Community Services	Assoc. of Community Services of Howard County	(410) 730-3710
Community Services	Community Assistance Network	(410) 747-3312
Counseling	Teen Parenting Enrichment Place	(410) 728-7878
Counseling	The Family Place	(410) 550-9025
Counseling	Tressler Lutheran Services of MD, Inc.	(410) 532-9600
Counseling for the blind	National Federation of the Blind	(410) 659-9314
Day treatment programs, has a list of resources	Brain Injury Association of Maryland Inc.	(410) 448 2924
Developmental Disabilities	MD. Assoc. of Comm. Svc. For Persons w/ DD	(410) 720-3030
Developmental Disabilities	The League: Serving People w/ Physical Disabilities	(410) 323-0500
Developmental Disabilities-ARC (Assoc. of Retarded Citizens)	Anne Arundel County Association for Retarded Citizens	(410) 269-1883
Developmental Disabilities-HOME/COMMUNITY THERAPY PROGRAM	Easter Seal Society for Disabled Children/Adults	(410) 298-0991
Food, Shelter	Community Assistance Network	(410) 285-4674
Hemophilia Foundation	National Hemophilia Foundation	(410) 288-3955
HIV/AIDS	HIV/AIDS Support Group	(410) 337-3330
HIV/AIDS	MD. AIDS Hotline - Information and Referral	(410) 945-2437
HIV/AIDS	Movable Feast, Inc.	(410) 234-4604
HIV/AIDS	Project Home	(410) 767-7340
HIV/AIDS	PWA Coalition of Baltimore, Inc.	(410) 625-1677
HIV/AIDS-Comprehensive Services	HERO(Health Education Resources Organization)	(410) 625-1180
HIV/AIDS-Resource Guide	AIDS Action Baltimore, Inc.	(410) 837-2437
Housing and Emergency services	Baltimore City Shelter Hotline	(410) 361-4663/4673
Housing and Emergency services	Baltimore Rescue Mission	(410) 342-2533
Housing and Emergency services	Beans and Bread	(410) 732-1892
Housing and Emergency services	Mayor's Office of Homeless Services	(410) 396-3757
Housing and Emergency services	My Sister's Place(ACC)	(410) 727-3523
Housing and Emergency services	Phoenix Place	(410) 467-1264
Housing and Emergency services	Project PLASE	(410) 837-1400
Housing and Emergency services	Salvation Army	(410) 366-4894
Housing and Emergency services	Transitional Housing Program	(410) 664-3636
Housing and Emergency Services(see Midtown Churches)	Manna House	(410) 889-3001
Individual and Family Support Services	The ARC of Frederick County	(301) 663-0909
Information and referral	American Lung Association	(410) 560 - 2120
Information and referral	Arthritis Foundation, Maryland Chapter	(410) 561-8090
Information and referral	Blind Industries and Services	(410) 233-4567
Information and referral	Cystic Fibrosis Foundation	(410) 771-9000
Information and referral	First Call for Help	(410) 685-0525
Information and referral	Governor's Office for Ind. With Disabilities	(410) 333-3098
Information and referral	Kidney Foundation of Maryland	(410) 494-8545
Information and referral	Maryland Diabetic Association	(410) 486-5515
Information and referral	MD. Lupus Foundation	(410) 337-9000
Information and referral	Muscular Dystrophy Association	(410) 252-5910

<b>Services Offered</b>	<b>Group Name</b>	<b>Phone</b>
Information and referral	National Multiple Sclerosis Society - So. MD. Chap	(410) 987-3902
Information and referral	The Sickle Cell Connection	(410) 362-3369
Information/Educational Service, active in schools	Asthma/Allergy Foundation of America - MD Chapter	(410) 532-4135 or (410) 321-4710
Nutritional Services	Clintec Home Link	(800) 776-5446
Nutritional Services	Digestive Disorders	(410) 224-4887
Nutritional Services	Dimensions in Food and Nutrition	(301) 854-0853
Nutritional Services	Eating Together Program	(410) 664-0700
Nutritional Services	HomeMed Lifeline	(301) 572-1544
Nutritional Services	Surplus Food Distribution	(410) 396-0416
Outpatient Drug and Alcohol	Overcome Substance Abuse Program	(410) 383-4982
Parent Education classes-more info on the way	Parents Place of Maryland, Inc.	(410) 712-0900
Patient Education	National Osteoporosis Foundation	(410) 576-8541
Public Policy Reform and Development	Action for The Homeless	(410) 659-0300
Referral Service for Child Care options	Locate Child Care - Balto County	(410) 887-6171
Referral Services, Support Groups, Etc.	American Diabetes Association of Maryland	(410) 526-2900
Referral Services, Support Groups, Etc.	Baltimore Association for Retarded Citizens	(410) 296-2272
Referral Services, Support Groups, Etc.	Diabetes Support Group	(410) 522-8119
Referral Services, Support Groups, Etc.	Epilepsy Association of Maryland	(410) 828-7700
Referral Services, Support Groups, Etc.	Lupus Support Group	(410) 532-3838
Referral Services, Support Groups, Etc.	Stop Smoking Support Group	(410) 682-7617
Referral Services, Support Groups, Etc.	Stroke Club Support Group	(410) 532-3838
Referral Services, Support Groups, Etc.	United Cerebral Palsy of Central Maryland	(410) 484-4540
Referral Services, Support Groups, Etc.- Transportation and drugs/medicines	Leukemia Society of America	(410) 825-2500
Referral Services, Support Groups, etc.-Women with Cancer	Arm in Arm	(410) 494-0083
Registration of all birth, death and marriage licenses in MD	Birth and Death Certificates	(800) 832-3277
Research Based Non-Profit Organization	Juvenile Diabetes Foundation	(410) 356-4555
Residential Program/Job Placement	Community Choice-(ARC of Howard County)	(410) 730-0638
Residential/Employment/Individual Support Services	United Cerebral Palsy of Southern MD (main office)	(410) 263-9600
Residential/Employment/Living Arrangement Services	United Cerebral Palsy of MD (St. Mary's Co. office)	(301) 863-8870
Residential/Vocational/Transportation/Respite Care	Carroll County Association for Retarded Citizens	(410) 848-4124 or (410) 879-2422
Screening, treatment, education, counseling	Sickle Cell Disease Assoc.of America-MD chapter	(410) 383-2214
Shelters and counsels homeless males	South Baltimore Homeless Shelter, Inc.	(410) 752-5917
Social services, English classes, Health fairs	Hispanic Apostolate	(410) 522-2668



## **Appendix C**

# **EPSDT Periodicity Schedule**

## MARYLAND PHYSICIANS CARE

### Healthy Kids (EPSDT) Program

#### Overview

---

*The Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program, known in Maryland as the Healthy Kids Program, is a preventive health program for children under the age of 21. It is designed to identify health problems early so that treatment can be initiated before they become serious or life threatening. The EPSDT program is a federal requirement and is implemented at the State level. COMAR10.09.23. Participating primary care physicians (PCPs) and Maryland Physicians Care must follow federal and state rules and regulations governing the provision of EPSDT services.*

Maryland Physicians Care's EPSDT Health Management Initiative is designed to support physicians and improve the health outcomes of members. The primary goal is to encourage members to actively participate in their health care. A multi-disciplinary team approach is used to identify and assess members with special health care needs and to communicate with physicians to facilitate coordination of care and utilization of community resources.

#### Screening Components

##### **Periodic Screening Services:**

Comprehensive, periodic screenings are to be conducted according to the time frames specified in the Preventive Schedule. The Periodicity Schedule specifies screening services at each stage of the child's life and is intended to meet reasonable standards of medical and dental practice. It is important for providers to use each encounter to assess immunization status and deliver needed services.

##### **Healthy Kids (EPSDT) screening services include the following:**

- A comprehensive health and developmental history (including both physical and behavioral health assessment)
- A comprehensive unclothed physical exam
- Appropriate immunizations according to age and health history
- Laboratory tests (including blood lead level tests appropriate to age and risk)
- Health education/anticipatory guidance
- Dental screening and referral
- Appropriate vision and hearing testing

##### **Initial Screening Services:**

When a child is enrolled in Maryland Physicians Care, an initial screening must be scheduled with the PCP according to the following:

- Within 90 days from the date of enrollment, or
- At a shorter interval to ensure that a newly enrolled child receives the appropriate health care services in a timely manner (This includes newborns who need a 14-day or one-month check-up, newly enrolled under-two year olds who are to be scheduled within 30 days of enrollment or a child in need of an initial evaluation for a health condition identified on the Health Risk Assessment), or

At an interval consistent with the Schedule of Preventive Health Care if the child was established in the PCP's practice prior to the child's enrollment with MPC.

Members are informed about the EPSDT program upon enrollment by MPC. They are sent a welcome packet, which includes a member handbook and information on the preventive and immunization schedule. MPC maintains a patient notification system for routine EPSDT visits and dental care. In addition, the prevention and wellness staff monitors for under-utilization and delayed services and works closely with the PCP to coordinate additional outreach and referrals to case management. Providers are encouraged to contact also responsible for missed appointment outreach.

### **Diagnosis, Treatment and Referral**

Problems found as a result of an EPSDT screening service are to be followed up with diagnosis and treatment. If there is a certain disease, illness or condition which is not appropriate for the PCP to treat, the member must be referred to an appropriate physician or specialist according to MPC's referral policies.

### **Documentation**

All EPSDT services and outreach must be documented in the medical record according to MPC Medical Record Standards. MPC also recommends that participating primary care providers use age-specific EPSDT encounter forms for all EPSDT visits. Copies of these forms are available through the Maryland Healthy Kids/Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program at 1-410-767-1683 **or visit them at: [www.dhmh.state.md.us/epsdt/healthykids](http://www.dhmh.state.md.us/epsdt/healthykids)**

### **Monitoring and Oversight**

MPC is responsible for monitoring the provision of EPSDT services to plan members. This includes reviewing the services provided at each EPSDT exam for appropriate screening, diagnosis, treatment, referral and follow up. MPC's staff maintains close contact with all PCPs caring for members under 21 years to assure compliance with the federal and state program requirements. Compliance with the Healthy Kids Program and MPC's guidelines is also monitored during routine quality management visits, medical record reviews and other clinical studies.



### **Assistance**

MPC and the primary care provider work as a team to promote wellness through prevention, education, outreach, early diagnosis and timely treatment. MPC's health educators are available to provide to assist providers with the Healthy Kids Program and member education.

If you have any questions regarding the program requirements or need assistance in managing a patient, please feel free to call the Prevention and Wellness Staff or your Provider Relations Representative. Additional information on requirements can also be found in The Maryland Healthy Kids Screening Provider Manual. To obtain a manual, please contact the Healthy Kids program at 1-410-767-1683 **or visit them at: [www.dhmh.state.md.us/epsdt/healthykids](http://www.dhmh.state.md.us/epsdt/healthykids).**



## **Appendix D**

### **Preventive Screenings**





## Schedule of Preventive Health Care

The chart below lists services that you, as a provider, may or may not need to perform to help prevent certain illnesses for your members. These services can also help find health problems (like cancer or high blood pressure) early, so that they can be treated as soon as possible.

TYPE OF SERVICE	HOW OFTEN
Physical exam	Every 2 years
Blood pressure check	Every 2 years
Cholesterol check	Every 5 years
Breast exam	Every 1-2 years
Mammogram	
Age: 35-40	Every 2 years
40-49	Every 2 years
50 and over	Every year
Pap smear	Every 1-2 years
Check for colorectal cancer	Every 2 years
Testicular exam	Every 2 years Between ages 18-39
Flu vaccine	Ask your provider if you're at risk
Pneumonia vaccine	Ask your provider if you're at risk
Td (Tetanus diphtheria)	Every 10 years
Health education	Every visit

These are only guidelines to follow. Depending on your patient, you may want to perform these services more or less often on your members. Talk to your member about what is right for them.



## **Appendix E**

# **Laboratory, Radiology & DME Codes**

## Pathology & Laboratory (Organ or Disease Oriented Panels) Microbiology

**\*\*\* Please note: CPT & HCPCS for laboratory and radiology are subject to code set updates**

- 80048** Basic metabolic panel
- 80050** General Health Panel
- 80051** Electrolyte Panel
- 80053** Comprehensive metabolic panel
- 80069** Renal function panel
- 80076** Hepatic function panel
- 80152** *Aitriptyline*
- 80154** *Benzodiazepines*
- 80156** *Carbamazepine; total*
- 80157** *free*
- 80160** *Desipramine*
- 80162** *Digoxin*
- 80164** *Dipropylacetic acid (valproic acid)*
- 80166** *Doxepin*
- 80168** *Ethosuximide*
- 80172** *Gold*
- 80173** *Haloperidol*
- 80174** *Imipramine*
- 80176** *Lidocaine*
- 80178** *Lithium*
- 80182** *Nortriptyline*
- 80184** *Phenobarbital*
- 80185** *Phenytoin; total*
- 80186** *free*
- 80188** *Primidone*
- 80190** *Procaïnamide*
- 80192** *with metabolites (eg n-acetyl procaïnamide)*
- 80194** *Quindine*
- 80196** *Salicylate*
- 80198** *Theophylline*
- 81000** Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
- 81001** automated, with microscopy
- 81002** non-automated, without microscopy
- 81003** automated, without microscopy
- 81005** Urinalysis, qualitative or semiquantitative, except immunoassays
- 81025** Urine pregnancy test, by visual color comparison methods
- 82043** *Albumin; urine, microalbumin, quantitative*
- 82465** Cholesterol, serum or whole blood, total
- 82565** *Creatinine; blood*
- 82570** *other source*
- 83036** *glycosylated (A1C) - Hemoglobin A1C*
- 84132** Potassium; serum

**84152** Prostate specific antigen (PSA); complexed (direct measurement)  
**84153** Total  
**84154** Free  
**84443** Thyroid stimulating hormone (TSH)  
**84702** Gonadotropin, chorionic (hCG); quantitative  
**84703** qualitative  
**85004** Blood count; automated differential WBC count  
**85007** blood smear, microscopic examination with manual differential WBC count  
**85008** blood smear, microscopic examination without manual differential WBC count  
**85009** manual differential WBC count, buffy coat  
**85014** hematocrit (Hct)  
**85018** hemoglobin (Hgb)  
**85025** *completed (CBC), aothomated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count*  
**85027** *Blood count; complete (CBC); automated (Hgb, Hct, RBC,WBC, and platelet count)*  
**85610** *Prothrombin time*  
**86001** *Lipid Panel*  
**86701** *HIV-1*  
**86803** *Hepatitis C antibody*  
**87075** any source, except blood, anaerobic with isolation and presumptive identification of isolates  
**87076** anaerobic isolate, additional methods required for definititive identification, each isolate  
**87077** aerobic isolate, additional methods required for definitive identification , each isolate  
**87081** Culture, presumptive, pathogenic organisms, screening only;  
**87084** with colony estimation from density chart  
**87086** Culture, bacterial; quantitative colony count, urine  
**87088** with isolation and presumptive identification of isolates, urine  
**87270** Chlamydia trachomatis  
**87273** Herpes simplex virus type 2  
**87320** Chlamydia tachomatis  
**87340** *Hepatits B surface antigen (HBsAg)*  
**87490** Chlamydia trachomatis, direct probe technique  
**87491** Chlamydia trachomatis, amplified probe technique  
**87492** Chlamydia trachomatis, quantification  
**87510** Gardnerella vaginalis, direct probe technique  
**87511** Gardnerella vaginalis, amplified probe technique  
**87512** Gardnerella vaginalis, quantification  
**87590** Neisseria gonorrhoeae, direct probe technique  
**87591** Neisseria gonorrhoeae, amplified probe technique  
**87592** Neisseria gonorrhoeae, quantification  
**87620** *papillomavirus, human, direct probe technique*  
**87621** *papillomavirus, human, amplified probe technique*  
**87622** *papillomavirus, human, quantification*  
**87810** Infectious agent detection by immunoassay w/drect optical observation; Chlamydia trachomatis  
**87850** Neisseria gonnorrhoeae  
**88141** Cytopathology, cervical or vaginal (any reporting system) requiring interpretation by physician  
**88142** Cytopathology, cervical or vaginal (any reporting system) collected in preservative fluid, automated thin layer preparation manual screening under physician supervision

- 88143** with manual screening and rescreening under physician supervision
- 88147** Cytopathology smears, cervical or vaginal, screening by automated system under physician interpretation
- 88148** screening by automated system with manual rescreening under physician supervision
- 88150** Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
- 88152** with manual screening and computer assisted rescreening under physician supervision
- 88153** with manual screening and rescreening under physician supervision
- 88154** with manual screening and computer assisted rescreening using cell selection and review under physician supervision
- 88155** Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code(s) for other technical and interpretation services)
- 88161** preparation, screening and interpretation

## **RADIOLOGY**

**\*\*\* Please note: CPT & HCPCS for laboratory and radiology are subject to code set updates**

- 70100** Radiologic examination, mandible; partial, less than four views
- 70110** complete, minimum of four views
- 70140** Radiologic examination, facial bones: less than three
- 70150** complete, minimum of three views
- 70160** Radiologic examination, nasal bones, complete, minimum of three views
- 71010** Radiologic examination, chest; single view; frontal and lateral
- 71015** sterneo, frontal
- 71020** Radiologic examination, chest, two views, frontal and lateral
- 71022** with oblique projections
- 71100** Radiologic examination, ribs, unilateral; two views
- 71101** including posteroanterior chest, minimum of three views
- 71110** Radiologic examination, ribs, bilateral; three views
- 71111** including posteroanterior chest, minimum of four views
- 73000** Radiologic examination; clavicle, complete
- 73010** scapula, complete
- 73020** Radiologic examination, shoulder; one view
- 73030** complete, minimum of two views
- 73050** Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction
- 73060** humerus, minimum of two views
- 73070** Radiologic examination, elbows; two views
- 73080** complete, minimum of three views
- 73090** Radiologic examination; forearm, two views
- 73092** upper extremity, infant, minimum of two views
- 73100** Radiologic examination, wrist; two views
- 73110** complete, minimum of three views
- 73120** Radiologic examination, hand; two views
- 73130** minimum of two views
- 73140** Radiologic examination, finger(s) minimum of two views
- 73500** Radiologic examination, hip, unilateral, one view
- 73510** complete, minimum of two views
- 73520** Radiologic examination, hips, bilateral minimum of two views of each hip, including anteroposterior view of pelvis

- 73550 Radiologic examination, femur, two views
- 73560 Radiologic examination, knee; one or two views
- 73562 three views
- 73564 complete, four or more views
- 73565 both knees, standing, anteroposterior
- 73590 Radiologic examination; tibia and fibula, two views
- 73592 lower extremity, infant, minimum of two views
- 73600 Radiologic examination, ankle, two views
- 73610 complete, minimum of three views
- 73620 Radiologic examination, foot; two views
- 73630 complete, minimum of three views
- 73650 Radiologic examination; calcaneus, minimum of two views
- 73660 toe(s), minimum of two views
- 74000 Radiologic examination, abdomen, single anteroposterior view
- 74010 anteroposterior and additional oblique and cone views
- 74020 complete, including decubitus and/or erect views
- 74022 complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest
- 76090 Mammography; unilateral
- 76091 bilateral
- 76092 Screening mammography, bilateral (two view film study of each breast)

## **DME Covered Codes**

---

**\*\*\* Please note: HCPCS durable medical equipment are subject to code set updates**

### **ORTHOPEDIC SHOES**

- L3000 Foot insert, removable, molded to patient model, UCB type, Berkeley shell, each
- L3001 Foot insert, removable, molded to patient model, Spenco, each
- L3002 Foot insert, removable, molded to patient model, Plastazote or equal, each
- L3003 Foot insert, removable, molded to patient model, silicone gel, each
- L3010 Foot insert, removable, molded to patient model, longitudinal arch support, each
- L3020 Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each
- L3030 Foot insert, removable, formed to patient foot, each
- L3031 Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each

### **ARCH SUPPORT, REMOVABLE, PREMOLDED**

- L3040 Foot, arch support, removable, premolded, longitudinal, each
- L3050 Foot, arch support, removable, premolded, metatarsal, each
- L3060 Foot, arch support, removable, premolded, longitudinal/metatarsal, each

### **MEDICAL AND SURGICAL SUPPLIES**

- A4245 Alcohol wipes, per box
- A4245 Urine test or reagent strips or tablets (100 tablets or strips)
- A4253 Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
- A4255 Platforms for home blood glucose monitor, 50 per box
- A4259 Lancets, per box of 100
- A6530 Gradient compression stocking, below knee, 18-30 mm Hg, each
- A6531 Gradient compression stocking, below knee, 30-40 mm Hg, each
- A6532 Gradient compression stocking, below knee, 40-50 mm Hg, each

- A6533 Gradient compression stocking, thigh length, 18-30 mm Hg, each
- A6534 Gradient compression stocking, thigh length, 30-40 mm Hg, each
- A6535 Gradient compression stocking, thigh length, 40-50 mm Hg, each
- A6536 Gradient compression stocking, full length/chap style, 18-30 mm Hg, each
- A6537 Gradient compression stocking, full length/chap style, 30-40 mm Hg, each
- A6538 Gradient compression stocking, full length/chap style, 40-50 mm Hg, each
- A6539 Gradient compression stocking, waist length, 18-30 mm Hg, each
- A6540 Gradient compression stocking, waist length, 30-40 mm Hg, each
- A6541 Gradient compression stocking, waist length, 40-50 mm Hg, each
- A6542 Gradient compression stocking, custom made
- A6543 Gradient compression stocking, lymphedema
- A6544 Gradient compression stocking, garter belt
- A6549 Gradient compression stocking, not otherwise

**DURABLE MEDICAL EQUIPMENT**

**CANES**

- E0100 Cane, includes canes of all materials, adjustable or fixed, with tip
- E0105 Cane, quad or three-prong, includes canes of all materials, adjustable or fixed, with tip

**CRUTCHES**

- E0110 Crutches, forearm, includes crutches of various materials, adjustment or fixed, pair, completed with tips and handgrips
- E0111 Crutch, forearm, includes of various materials, adjustable or fixed, each, with tip and handgrip
- E0112 Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips
- E0113 Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip
- E0114 Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips or handgrips
- E0116 Crutch, underarm, other than wood adjustable or fixed, with PAD, tip, handgrip, with or without shock absorber, each
- E0117 Crutch, underarm, articulating, spring assisted, each
- E0118 Crutch substitute, lower leg platform, with or without wheels, each
- E0130 Walker, rigid (pickup), adjustable or fixed height
- E0135 Walker, folding (pickup, adjustable or fixed height
- E0140 Walker, with trunk support, adjustable or fixed height, any type
- E0141 Walker, rigid, wheeled, adjustable or fixed height
- E0143 Walker, folding, wheeled, adjustable or fixed height
- E0144 Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat
- E0147 Walker, heavy duty, multiple braking system, variable wheel resistance
- E0148 Walker, heavy duty, without wheels, rigid or folding, any type, each
- E0149 Walker, heavy duty, wheeled, rigid or folding, any type
- E0153 Platform attachment, forearm crutch, each
- E0154 Platform attachment, walker, each
- E0155 Wheel attachment, rigid pick-up walker, per pair seat attachment, walker
- E0607 Home blood glucose monitor

**ATTACHMENTS**

- E0156 Seat attachment, walker
- E0157 Crutch attachment, walker, each
- E0158 Leg extensions for walker, per set of four (4)
- E0159 Brake attachment for wheeled walker, replacement, each

