maryland physicians care

Help is Here

HealthChoice Provider Manual

Managed Care That's Easy to Manage.

maryland physicians care
Medicaid with a Heart

1201 Winterson Road
4th Floor
Linthicum Heights, MD
21090

Toll-Free
1-800-953-8854
mpcMedicaid.com

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Help is Here

HELPFUL INFORMATION

Maryland Physicians Care
Office Hours:
Monday–Friday, 8 a.m. to 5 p.m.

Provider Services
1-800-953-8854

Provider Hotline
1-800-766-8692

Maryland TDD Relay Service
1-800-735-2258

Superior Vision
1-800-428-8789

Maryland Healthy Smiles Dental Program
1-855-934-9812

Drug and/or Alcohol
Treatment Center Help
1-800-953-8854

Express Scripts
1-800-753-2851

CuraScript
1-877-599-7748

State of Maryland Public
Mental Health System
1-800-888-1965

State of Maryland Hotline
1-800-492-5231

State of Maryland Rare and Expensive
Case Management Program (REM)
1-800-565-8190

State of Maryland Enrollment Broker
1-800-977-7388

State of Maryland Eligibility Verification
System (EVS)
1-866-710-1447

Maryland Physicians Care
HealthChoice
Provider Manual

Updated October 2024

HealthChoice Provider Manual
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SECTION I.
INTRODUCTION

THE MARYLAND HEALTHCHOICE PROGRAM

MEDICAID and HEALTHCHOICE

HealthChoice is the name of Maryland Medicaid's managed care program. There are approximately 1.7 million Marylanders enrolled in Medicaid and the Maryland Children's Health Program. With few exceptions Medicaid beneficiaries under age 65 must enroll in HealthChoice. Individuals that do not select a Managed Care Organization (MCO) will be auto-assigned to an MCO with available capacity that accepts new enrollees in the county where the beneficiary lives. Individuals may apply for Medicaid, renew their eligibility and select their MCO on-line at www.marylandhealthconnection.gov or by calling 1-855-642-8572 (TYY: 1-855-642-8572. Members are encouraged to select an MCO that their PCP participates with. If they do not have a PCP they can choose one at the time of enrollment. MCO members who are initially auto-assigned can change MCOs within 90 days of enrollment. Members have the right to change MCOs once every 12 months. The HealthChoice Program's goal is to provide patient-focused, accessible, cost-effective, high quality health care**.** The State assesses the quality of services provided by MCOs through various processes and data reports. To learn more about the State's quality initiatives and oversight of the HealthChoice Program go to: https://health.maryland.gov/mmcp/healthchoice/Pages/Home.aspx

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

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

Introduction to Maryland Physicians Care

Welcome to the Maryland Physicians Care Provider Network. Maryland Physicians Care is a local, provider-owned, leading Medicaid Managed Care Organization in the State of Maryland that administers high-quality health care services to over 200,000 qualifying HealthChoice recipients. For over 20 years, Maryland Physicians Care has partnered with a comprehensive network of hospitals, doctors, clinics and pharmacies committed to transforming the health of the community we serve. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high quality provider network.

This Provider Manual is designed to answer your questions and provides a description of our policies and procedures. Maryland Physicians Care will send updates via written or e-mail communications as needed and will incorporate any changes to this Manual online at www.marylandphysicianscare.com.

Our website offers a wealth of resources for providers and a list of Provider Relations representatives by territory is available should you have any questions. We appreciate your partnership with Maryland Physicians Care and thank you for the care you provide to members.

Member Rights and Responsibilities

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

- Receive health care and services that are culturally competent and free from discrimination.
- Be treated with respect to your dignity and privacy.
- Receive information, including information on treatment options and alternatives, regardless of cost or benefit coverage, in a manner you can understand.
- Participate in decisions regarding your healthcare, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of your medical records and request that they be amended or corrected as allowed.
- Request copies of all documents, records, and other information free of charge, that was used in an adverse benefit determination.
- Exercise your rights, and that the exercise of those rights does not adversely affect the way the Managed Care Organizations (MCO), their providers, or the Maryland Department of Health treat you.
- File appeals and grievances with a Managed Care Organization.
- File appeals, grievances and State fair hearings with the State.
- Request that ongoing benefits be continued during an appeal or state fair hearing however, you may have to pay for the continued benefits if the decision is upheld in the appeal or hearing. Receive a second opinion from another doctor within the same MCO, or by an out of network provider if the provider is not available within the MCO, if you do not agree with your doctor's opinion about the services that you need. Contact your MCO for help with this.
- Receive other information about how your Managed Care Organization is managed including the structure and operation of the MCO as well as physician incentive plans. You may request this information by calling your Managed Care Organization**.**
- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Make recommendations regarding the organization's member rights and responsibilities policy.

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

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

- Use the emergency department for emergencies only.
- Tell your PCP as soon as possible after you receive emergency care.
- Inform your caregiver about any changes to your Advance Directive.

HIPAA and Member Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) require MCOs and providers to report their privacy practices to their members. The Notice of Privacy Practices informs members of their rights to privacy as well as the access and disclosure of their protected health information (PHI). Examples of PHI include medical records, medical claims/billing, and health plan records. If you feel that your privacy rights have been violated, you can file a complaint with your provider, MCO, or the U.S. Department of Health and Human Services.
Maryland Physicians Care members have the right to:

- Review their health information.
- Ask Maryland Physicians Care to change their health information.
- Get a list of people or groups that Maryland Physicians Care has shared health information with.
- Ask for privacy when communicating with Maryland Physicians Care.
- Ask for special care in how Maryland Physicians Care use or share health information.
- Know if health information was shared without the member's approval.

Anti-Gag Provisions

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

(1) Communications that relate to treatment alternatives including medication treatment options regardless of benefit coverage limitations;
(2) Communication that is necessary or appropriate to maintain the provider-patient relationship while the member is under the Participating Physician's care;
(3) Communications that relate to a member's or subscriber's right to appeal a coverage determination with which the Participating Physician, member, enrollee, or subscriber does not agree; and
(4) Opinions and the basis of an opinion about public policy issues.

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

Assignment and Reassignment of Members

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

- If they move to another county where Maryland Physicians Care does not offer care;
- If they become homeless and find that there is another MCO closer to where they live or have shelter which

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

Once an individual chooses or is auto-assigned to Maryland Physicians Care and selects a Primary Care Provider, Maryland Physicians Care enrolls the member into that practice and mails them a member ID card. Maryland Physicians Care will choose a PCP close to the member's residence if a PCP is not selected.

Maryland Physicians Care is required to provide PCPs with their rosters on a monthly basis**.** Members will become effective with Maryland Physicians Care on a daily basis. PCPs will occasionally be responsible for the care of some members who are not on their most recent PCP roster. If a member presents who does not appear on a PCP roster, the PCP may verify the eligibility and effective date with Maryland Physicians Care by accessing our secure online web portal, accessible via our website at MarylandPhysiciansCare.com**.**

There will also be instances in which a person may be notified of the PCP assignment before his/her effective date. The name of the member's PCP will be on their Maryland Physicians Care card. Any questions a PCP has concerning eligibility or PCP assignment can be directed to Maryland Physicians Care Member Services staff.

MCO members may change PCPs at any time. Members can call Maryland Physicians Care Member Services Monday-Friday 8 a.m. – 5:00 p.m. at 1-800-953-8854 to change their PCP.

PCPs may see Maryland Physicians Care members even if the PCP name is not listed on the membership card. As long as the member is eligible on the date of service and the PCP is participating with Maryland Physicians Care, the PCP may see the Maryland Physicians Care member. However, Maryland Physicians Care does request that the PCP assist the member in changing PCPs so the correct PCP is reflected on the membership card.

Credentialing and Contracting with Maryland Physicians Care

Maryland Physicians Care credentials providers according to nationally recognized standards. Participating providers must meet the criteria established by Maryland Physicians Care, as well as government regulations and standards of accrediting bodies. The Credentialing Committee will review all applicants with a completed application. Based on the credentialing criteria, the committee will either approve or deny the application.

Maryland Physicians Care does not base credentialing decisions for a provider who is acting within the scope of that provider's license or certification under applicable state law on that provider's race, ethnic/national identity, gender, age, or sexual orientation. Please ensure you have a current attestation in CAQH and that all the credentialing documents are current in the record.

Credentialing is required for all providers except Hospital Based Physicians. The credentialing process can take up to 120 days from the date Maryland Physicians Care begins the credentialing process.

The following information is required to begin the Credentialing process:

Professional

- Physician Credentialing Application (for practitioners)
  -If a physician/practitioner is not affiliated with CAQH, a paper application is required along with an updated attestation and all required licensure
- Site Visit (for new PCPs and OBGYNs)
  -Facility
  -Appointment Availability
  -Medical Records Review (MRR)
- EPSDT Intent

Facility

- Facility/Organization Provider Application
- Accreditation Certificate
- Copy of Current State License
- Business License

Credentialing <u>is required</u> for:

Medical Doctors (MD)
Doctor of Osteopathy (DO)
Certified Registered Nurse Practitioners (CRNP)
Chiropractors (DC)
Doctor of Podiatric Medicine (DPM)
Home Health
Ambulatory Surgery Center (ASC)

Credentialing <u>is not required</u> for:

Pathology
Physical Therapy
Doctor of Philosophy (PHD)
Mental Health
Nutritionist
Anesthesiologist
Radiologist
Hospitalist
Certified Registered Nurse Anesthetists (CRNA)
Dialysis
Durable Medical Equipment

Practitioner Credentialing Rights

Practitioners have the right to:

- Review information submitted to support their credentialing application.
- Correct erroneous information.
- Receive the status of their credentialing or recredentialing application, upon request.

If you have any questions or to check the status please contact Provider Relations at 1-800-953-8854 or by email at: ProviderRelations@mpcMedicaid.com.

Provider Reimbursement

Payment to providers is in accordance with your provider contract with Maryland Physicians Care or with their management groups that contract on your behalf with Maryland Physicians Care. In accordance with the Maryland Annotated Code, Health General Article 15-1005, we must mail or transmit payment to our providers eligible for reimbursement for covered services within 30 days after receipt of a clean claim. If additional information is necessary, we shall reimburse providers for covered services within 30 days after receipt of all reasonable and necessary documentation. We shall pay interest on the amount of the clean claim that remains unpaid 30 days after the claim is filed.

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

Self-Referral and Emergency Services

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

The State allows members to self-refer to out of network providers for the services listed below. Maryland Physicians Care will **pay out of plan providers** the State's Medicaid rate for the following services:

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

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

Maryland Continuity of Care Provisions

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

- Is new to the HealthChoice Program;
- Switched from another company's health benefit plan; or
- Switched to Maryland Physicians Care from another MCO.

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

- Dental Services
- Mental Health Services
- Substance Use Disorder Services
- Benefits or services provided through the Maryland Medicaid fee-for-service program
- Post-acute service claims, if the member is no longer eligible with the plan. Please verify eligibility with Maryland Medicaid.

Preauthorization for health care services

If the previous MCO or company preauthorized services, we will honor the approval if the member calls 1-800-953-8854. Under Maryland law, insurers must provide a copy of the preauthorization within 10 days of the member's request. There is a time limit for how long we must honor this preauthorization. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health practitioner after the baby is born.

Right to use non-participating providers

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

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

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

If the member has any questions, they should call Maryland Physicians Care Member Services at 1-800-953-8854 or the State's HealthChoice Help Line at 1-800-284-4510.

Section II.

OUTREACH AND SUPPORT SERVICES, APPOINTMENT SCHEDULING, EPSDT AND SPECIAL POPULATIONS

MCO Member Outreach and Support Services

Maryland Physicians Care operates a mixed model (a combination of direct staffing and network contracting activities) for delivering outreach services to our members. Under this model, Maryland Physicians Care has multiple departments to conduct member outreach services including: Case Management, Member Services Center, Member Connections, Quality Management and the Prevention and Wellness Unit. Maryland Physicians Care utilizes a health plan operating system to coordinate, track and report all outreach activities. This cross-departmental system allows all Maryland Physicians Care staff to access call notes and determine the outreach status as well as internal and external follow-up needs.

State Non-Emergency Medical Transportation (NEMT) Assistance

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

MCO Transportation Assistance

Under certain circumstances Maryland Physicians Care may provide limited transportation assistance when members do not qualify for NEMT through the LHD. Maryland Physicians Care provides non-emergency transportation to access a covered service if we choose to provide the service at a location that is outside of the closest county in which the service is available.

State Support Services

The State provides grants to local health departments to operate Administrative Care Coordination/Ombudsman services (ACCUs) to assist with outreach to certain non-complaint members and special populations as outlined below. MCOs and providers are encouraged to develop collaborative relationships with the local ACCU. **See Attachment III for the local ACCU contact information**. If you have questions call the Division of Community Liaison and Care Coordination at 410-767-6750, which oversees the ACCUs or the HealthChoice Provider Help Line at 1-800-766-8692.

Scheduling Initial Appointments

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

- You determine that no immediate initial appointment is necessary because the member already has an established relationship with you.
- For children under 21, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) periodicity schedule requires a visit in a shorter timeframe. For example, new members up to two years of age must have a well-child visit within 30 days of enrollment unless the child already has an established relationship with a provider and is not due for a well-child visit.
- For pregnant and post-partum members who have not started to receive care, the initial health visit must be scheduled, and the members seen within 10 days of a request.
- As part of the MCO enrollment process the State asks the member to complete a Health Services Needs Information (HSNI) form. This information is then transmitted to the MCO. A member who has an identified need must be seen for their initial health visit within 15 days of Maryland Physicians Care's receipt of the HSNI.
- During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age-appropriate physical exam.

- In addition, at the initial health visit, initial prenatal visit, or when a member's physical status, behavior, or laboratory findings indicate possible substance use disorder, you must refer the member to the Behavioral Health System at 1-800-888-1965.

Early Periodic Screening Diagnosis and Treatment (EPSDT) Requirements

Maryland Physicians Care will assign children and adolescents under age 21 to a PCP who is certified by the EPSDT/Healthy Kids Program. If member's parent, guardian, or caretaker, as appropriate, specifically requests assignment to a PCP who is not EPSDT-certified, the non-EPSDT provider is responsible for ensuring that the child receives well childcare according to the EPSDT schedule. If you provide primary care services to individuals under age 21 and are not EPSDT certified call (410) 767-1836. For more information about the HealthyKids/EPSDT Program and Expanded EPSDT services for children under age 21 go to https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx .

Providers must follow the Maryland Healthy Kids/EPSDT Program Periodicity Schedule and all associated rules to fulfill the requirements under Title XIX of the Social Security Act for providing children under 21 with EPSDT services. The Program requires you to:

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

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

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

- Is identified as being at risk of a developmental delay by the developmental screen required by EPSDT;
- Has a 25% or more delay in any developmental area as measured by appropriate diagnostic instruments and procedures;
- Manifests atypical development or behavior; or
- Has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

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

EPSDT Outreach and Referral to LHD

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

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

Schedule a second appointment within 30 days of the first missed appointment.
Within 10 days of the child missing the second consecutive appointment, request assistance in locating and contacting the child's parent, guardian or caretaker by calling Maryland Physicians Care at 1-800-953-8854. You may concurrently make a written referral to the LHD ACCU by completing the Local Health Services Request form. **See Attachment IV.** Continue to work collaboratively with Maryland Physicians Care and the ACCU until the child is in care and up to date with the EPSDT periodicity schedule or receives appropriate follow-up care.

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

Special Populations

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

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

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

- Demonstrate their credentials and experience to us in treating special populations.
- Collaborate with our case management staff on issues pertaining to the care of a special needs member.
- Document the plan of care and care modalities and update the plan annually.

Individuals in one or more of these special needs populations must receive services in the following manner from us and/or our providers:

- Upon the request of the member or the PCP, a case manager trained as a nurse or a social worker will be assigned to the member. The case manager will work with the member and the PCP to plan the treatment and

services needed. The case manager will not only help plan the care but will help keep track of the health care services the member receives during the year and serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.

- The PCP and our case managers, when required, coordinate referrals for needed specialty care. This includes specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. **PCPs should follow the referral protocols established by us for sending HealthChoice members to specialty care networks.**
- We have a Special Needs Coordinator on staff to focus on the concerns and issues of special needs populations. The Special Needs Coordinator helps members find information about their condition or suggests places in their area where they may receive community services and/or referrals. To contact the Special Needs Coordinator, call 1-800-953-8854.
- Providers are required to treat individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 (P.L. 101-336 42 U.S.C. 12101 et. seq. and regulations promulgated under it).

Special Needs Population-Outreach and Referral to the LHD

A member of a special needs population who fails to appear for appointments or who has been non-compliant with a regimen of care must be referred to Maryland Physicians Care. If a member continues to miss appointments, call Maryland Physicians Care at 1-800-953-8854. We will attempt to contact the member by mail, telephone and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the LHD ACCU. You may also make a written referral to the ACCU by completing the Local Health Services Request Form. **See Attachment IV or** https://mmcp.health.maryland.gov/pages/Local-Health-Services-Request-Form.aspx). The local ACCU staff will work collaboratively with Maryland Physicians Care to contact the member and encourage them to keep appointments and provide guidance on how to effectively use their Medicaid/HealthChoice benefits.

Services for Pregnant and Postpartum Members

Prenatal care providers are key to assuring that pregnant members have access to all available services. Many pregnant members will be new to HealthChoice and will only be enrolled in Medicaid during pregnancy and the postpartum period. Medicaid provides full benefits to these members during pregnancy and for one year after delivery after which they will automatically be enrolled in the Family Planning Waiver Program. (For more information visit:
https://health.maryland.gov/mmcp/Documents/Factsheet3_Medicaid%20Family%20Planning%20Program.pdf)
Maryland Physicians Care and our providers are responsible for providing pregnancy-related services, which include:

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

The State provides these additional services for pregnant members:

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

Encourage all pregnant members to call the State's Help Line for Pregnant Woman at 1-800-456-8900. This is especially important for members who are newly eligible or not yet enrolled in Medicaid. If the member is already enrolled in HealthChoice call us and also instruct them to call Maryland Physicians Care at 1-800-953-8854.

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

The prenatal care providers must follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic, if possible, notice to members of the prenatal appointment dates and times. The prenatal care provider, PCP and Maryland Physicians Care are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcomes. Examples of an appropriate referrals include the Women Infants and Children special supplemental nutritional program (WIC). Prenatal care providers are also required to:

- Provide the initial health visit within 10 days of the request.
- Complete the Maryland Prenatal Risk Assessment form-MDH 4850. **See Attachment V** during the initial visit and submit it to the Local Health Department within 10 days of the initial visit. Maryland Physicians Care will pay for the initial prenatal risk assessment- use CPT code H1000.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- At each visit provide health education relevant to the member's stage of pregnancy. Maryland Physicians Care will pay for this- use CPT code H1003 for an "Enriched Maternity Services"- You may only bill for one unit of "Enriched Maternity Services" per visit. Refer pregnant and postpartum members to the WIC Program. If under the age 21, refer the member to their PCP to have their EPSDT screening services provided.
- Reschedule appointments within 10 days if a member misses a prenatal appointment. Call Maryland Physicians Care if a prenatal appointment is not kept within 30 days of the first missed appointment.
- Refer pregnant members to the Maryland Healthy Smiles Dental Program. Members can contact Healthy Smiles at 1-855-934-9812; TDD: 855-934-9816; Web Portal: http://member.mdhealthysmiles.com/ if you have questions about dental benefits.
- Refer pregnant and postpartum members in need of diagnosis and treatment for a mental health or substance use disorder to the Behavioral Health System; if indicated they are required to arrange for substance abuse treatment within 24 hours.
- Educate eligible pregnant members on doula services or refer eligible members for home visits if medically necessary and appropriate.
- Record the member's choice of pediatric provider in the medical record prior to her eighth month of pregnancy. We can assist in choosing a PCP for the newborn. Advise the member that they should be prepared to name the newborn at birth. This is required for the hospital to complete the "Hospital Report of Newborns", MDH 1184. (The hospital must complete this form so Medicaid can issue the newborns ID number.) The newborn will be enrolled in the postpartum member's MCO.

Childbirth Related Provisions

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

If a member must remain in the hospital after childbirth for medical reasons, and the member requests that their newborn remain in the hospital while they are hospitalized, additional hospitalization of up to 4 days is covered for the newborn and must be provided.

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

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

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

If the member remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider, is covered.

Unless we provide for the service prior to discharge, a newborn's initial evaluation by an out-of-network on-call hospital physician before the newborn's hospital discharge is covered as a self-referred service.

We are required to schedule the newborn for a follow-up visit within 2 weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit. Breast pumps are covered under certain situations for breastfeeding members. Call us at 1-800-953-8854**.**

Children with Special Health Care Needs

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

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

Established Member: A child who is already enrolled in Maryland Physicians Care when diagnosed as having a special health care need requiring a plan of care that includes specific types of services may request a specific out-of-

network provider. We are obliged to grant the member's request unless we have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same services and service modalities.

If we deny, reduce, or terminate the services, members have an appeal right, regardless of whether they are a new or established member. Pending the outcome of an appeal, we may reimburse for services provided.

For children with special health care needs Maryland Physicians Care will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions, social services, or both, a multi-disciplinary team must be used to review and develop the plan of care for children with special health care needs.
- Refer special needs children to specialists as needed. This includes specialty referrals for children who have been found to be functioning one third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
- Allow children with special health care needs to access out-of-network specialty providers under certain circumstances. We log any complaints made to the State or to Maryland Physicians Care about a child who is denied a service by us. We will inform the State about all denials of service to children. All denial letters sent to children or their representative will state that members can appeal by calling the State's HealthChoice Help Line at (800) 284-4510.
- Work closely with the schools that provide education and family services programs to children with special needs.

Children in State-Supervised Care

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

Individuals with HIV/AIDS

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

- An HIV/AIDS specialist is provided for treatment and coordination of primary and specialty care.
- A diagnostic evaluation service (DES) assessment can be performed once every year at the member's request. The DES includes a physical, mental and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES for the evaluation.
- Substance use treatment is provided within 24 hours of request.
- The right to ask us to send them to a site doing HIV/AIDS related clinical trials. We may refer members who are individuals with HIV/AIDS to facilities or organizations that can provide the members access to clinical trials.
- Providers will maintain the confidentiality of client records and eligibility information, in accordance with all Federal, State and local laws and regulations, and use this information only to assist the participant in receiving needed health care services.

Maryland Physicians Care will provide case management services for any member who is diagnosed with HIV. These services will be provided with the member's consent and will facilitate timely and coordinated access to appropriate levels of care and support continuity of care across the continuum of qualified service providers. If a member initially refuses HIV case management services, they may request services at a later time. The member's

case manager will serve as the member's advocate to resolve differences between the member and providers pertaining to the course or content of therapeutic interventions.

Individuals with Physical or Developmental Disabilities

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

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

Homeless Individuals

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

Rare and Expensive Case Management Program

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

SECTION III.

HEALTHCHOICE BENEFITS AND SERVICES

MCO BENEFITS AND SERVICES OVERVIEW

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

Audiology Services

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

Blood and Blood Products

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

Case Management Services

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

Maryland Physicians Care support services

Maryland Physicians Care provides outreach and care management services to its HealthChoice members through collaboration with Maryland Physicians Care network entities, community partnerships (i.e., regional, non-governmental) and local health departments. Maryland Physicians Care operates a mixed model (a combination of direct staffing and network contracting activities) for delivering outreach services to our members. Under this model, Maryland Physicians Care has multiple departments to conduct member outreach services including: Case Management, Member Services Center, Quality Management and the Prevention and Wellness Unit. Maryland Physicians Care utilizes a health plan operating system to coordinate, track and report all outreach activities. This cross-departmental system allows all Maryland Physicians Care staff to access call tracking notes and determine the outreach status as well as internal and external follow-up needs.

Population Health Management

Population Health Management programs are offered to enrollees who need additional services and/or have special needs.

Referrals to these Programs

For more information or to make a referral, contact our Special Needs Coordinator at 443-300-7325 or fax to 1-844-284-7698 or by email at MBUMDMedicaidSpecialNeeds@marylandphysicianscare.com.

Our population health management programs are voluntary, and all members have the option to agree or decline the service without any impact on their benefits.

Outreach is provided for special needs populations through the Case Management department, while outreach to members with general needs, such as EPSDT compliance, is handled through the Member Services Department. Our contracted providers serve as an important resource in identifying members who require outreach services, and augmenting our plan-directed outreach activities with a provider-based approach. Face-to-face contact and assessment of members is done by the Local Health Departments in each county to locate members difficult to find

and bring them into care. We may work with community agencies, including local health departments, to get the word out to our members about Maryland Physicians Care's services.

Maryland Physicians Care's outreach program focuses on the following:

- Educate members about the importance of receiving health care from a single "medical home" (i.e., the primary care physician)
- Reinforce with members the importance of preventive and wellness care
- Assist members, when appropriate, to change at-risk behaviors that are adversely affecting their health status
- Assist members in scheduling and obtaining appropriate and timely preventive services

Clinical Trial Items and Services

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

Dental Services

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

Diabetes Care Services

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

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

Diabetes Prevention Program

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

- Are 18 to 64 years old
- Overweight or obese
- Have an elevated blood glucose level or a history of gestational diabetes mellitus
- Have never been diagnosed with diabetes; and
- Are not currently pregnant.

Diagnostic and Laboratory Services

Diagnostic services and laboratory services performed by providers who are CLIA certified or have a waiver of a certificate registration and a CLIA ID number are covered. However, viral load testing, Genotypic, phenotypic, or HIV/AIDS drug resistance testing used in treatment of HIV/AIDS are reimbursed by the State.

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

Disease Management
We offer disease management for members with the following chronic conditions:

- Diabetes
- Asthma

Disease management may be available for Maryland Physicians Care members for member with the above chronic conditions. Member referrals may be made by calling our Special Needs Coordinator at 1-800-953-8854.

Durable Medical Services and Durable Medical Equipment
We cover medically necessary DMS/DME services. We must provide authorization for DME and/or DMS within a timely manner so as not to adversely affect the member's health and within 2 business days of receipt of necessary clinical information but not later than 14 calendar days from the date of the initial request. We must pay for any durable medical equipment authorized for members even if delivery of the item occurs within 90 days after the member's disenrollment from Maryland Physicians Care, as long as the member remains Medicaid eligible during the 90-day time period.

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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
We must cover EPSDT services listed below for members under 21 years of age.

Well-child services provided in accordance with the EPSDT/Healthy Kids periodicity schedule by an EPSDT-certified provider, including:

- Periodic comprehensive physical examinations;
- Comprehensive health and developmental history, including an evaluation of both physical and mental health development;
- Immunizations;
- Laboratory tests including blood level assessments;
- Vision, hearing, and oral health screening; and
- Health education.

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

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

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

Family Planning Services

We will cover comprehensive family planning services such as:

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

Gender Affirming Services

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

Habilitation Services

We cover habilitation services when medically necessary for certain adults who are eligible for Medicaid under the ACA. These services include: physical therapy, occupational therapy and speech therapy. If you have questions about which adults are eligible call 1-800-953-8854.

Home Health Services

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

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

Hospice Care Services

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

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

Mobile Integrated Community Health
We cover mobile integrated health services provided by approved EMS agencies for eligible adults.

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

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

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

Oxygen and Related Respiratory Equipment
We cover oxygen and related respiratory equipment.

Pharmacy Services and Copays
We are responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. We cover medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider. Most behavioral health drugs are on the State's formulary and are the responsibility of the State.

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

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

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

Pregnancy-Related Care

Pregnancy-related service providers will follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic, if possible, notice to member of the prenatal appointment dates and times.

You must:

- Schedule prenatal appointments in a manner consistent with the ACOG guidelines
- Provide hours of operation for Medicaid members no less than for non-Medicaid members
- Provide the initial health visit within 10 days of the request
- Reschedule appointments within 10 days for members who miss prenatal appointments
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child
- Refer to the WIC program
- Refer pregnant members under the age of 21 to their PCP to have EPSDT screening services provided
- Refer pregnant and postpartum members who are in need of treatment for a substance use disorder for appropriate substance abuse assessments and treatment services through the Behavioral Health System
- Complete the Maryland Prenatal Risk Assessment form-DHMH 4850 (sample attached) for each pregnant member and submit it to the Local Health Department in the jurisdiction in which the member lives within 10 days of the initial visit
- Instruct pregnant members to notify the MCO of her pregnancy and her expected date of delivery after her initial prenatal visit
- Instruct the pregnant member to contact the MCO for assistance in choosing a PCP for the newborn prior to her eighth month of pregnancy
- Document the pregnant member's choice of pediatric provider in the medical record
- Advise pregnant member that they should be prepared to name the newborn at birth. This is required for the hospital to complete the "Hospital Report of Newborns", DHMH 1184 and get the newborn enrolled in HealthChoice.

Primary Behavioral Health Services

We cover primary behavioral health services, including assessment, clinical evaluation and referral for additional services. The PCP may elect to treat the member, if the treatment, including visits for Buprenorphine treatment, falls within the scope of the PCP's practice, training, and expertise. Referrals for behavioral health services can be made by calling the State's ASO at 1- 800-888-1965, Monday - Friday: 8:00 AM to 6:00 PM.

Specialty Care Services

Specialty care services provided by a physician or an advanced practice nurse (APN) are covered when services are medically necessary and are outside of the PCP's customary scope of practice. Specialty care services covered under this section also include:

- Services performed by non-physician, non-APN practitioners, within their scope of practice, employed by a physician to assist in the provision of specialty care services, and working under the physician's direct supervision;
- Services provided in a clinic by or under the direction of a physician or dentist; and
- Services performed by a dentist or dental surgeon, when the services are customarily performed by physicians.

A member's PCP is responsible for making the determination, based on our referral requirements, of whether or not

a specialty care referral is medically necessary. PCPs must follow our special referral protocol for children with special healthcare needs who suffer from a moderate to severe chronic health condition which:

- Has significant potential or actual impact on health and ability to function;
- Requires special health care services; and
- Is expected to last longer than 6 months.

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

Telemedicine and Remote Patient Monitoring

We must offer telemedicine and remote patient monitoring to the extent they are covered by the Medicaid FFS Program.

When your office is closed or appointments aren't available, Maryland Physicians Care members can utilize Maryland Physicians Care's telemedicine application MyVirtualMPC for access to Emergency Medicine Associates between 9 a.m.-9 p.m., seven days a week.

MyVirtualMPC and Emergency Medicine Associates complement the work your clinic is doing by providing virtual follow-up and alternative emergency care by a physician familiar with your patients and Maryland Physicians Care. MyVirtualMPC helps your Maryland Physicians Care patients avoid high-cost care at the emergency room or urgent care, reduces after hours calls to your answering service, and bridges patient care until they can see you again.

After speaking with a doctor on MyVirtualMPC, patients are then referred back to your office for additional care. MyVirtualMPC was built to work just like a text messaging app, making it easy for Maryland Physicians Care patients to immediately start texting or schedule a video appointment with a doctor. Your Maryland Physicians Care patients can register at MyVirtualMPC.com or by downloading the app from the App Store or on Google Play.

Transplants

We cover medically necessary transplants to the extent that the service would be covered by the State's fee-for-service program. Maryland Physicians Care utilizes a transplant network. Please contact us at 800-953-8854 to begin the authorization process.

Vision Care Services

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

OPTIONAL SERVICES COVERED BY MARYLAND PHYSICIANS CARE

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

Pharmacy Services (No Pharmacy Co-pays)

- Free prescriptions
- Over-the-counter medications

Visions Services for adults age 21 and older

- One eye exam every year
- One set of glasses OR contact lenses every two years
- One pair of lenses every year (when needed)

MEDICAID BENEFITS COVERED BY THE STATE - not covered by Maryland Physicians Care

- **The State covers dental** services for all members who receive full Medicaid benefits. The Maryland Healthy Smiles Dental Program is responsible for routine preventative services, restorative service and orthodontia. Orthodontia must meet certain criteria and requires preauthorization by SKYGEN USA the States ASO. SKYGEN USA assigns members to a dentist and issues a dental Healthy Smiles ID card. However, the member may go to any Healthy Smiles participating dentist. If you have questions about dental benefits call 1-855-934-9812.
- Outpatient rehabilitative services for children under age 21;
- Specialty mental health and substance use disorders covered by the Specialty Behavioral Health System;
- Intermediate Care Facilities for Individuals with Intellectual Disabilities or Persons with developmental disabilities;
- Personal care services;
- Medical day care services, for adults and children;
- Abortions (covered under limited circumstances – no Federal funds are used -claims are paid through the Maryland Medical Care Program). If a member was determined eligible for Medicaid based on their pregnancy they are not eligible for abortion services;
- Emergency transportation (billed by local EMS);
- Non-emergency transportation services provided through grants to local governments;
- Services provided to members participating in the State's Health Home Program; and
- Certain high-cost low-volume drugs.

BENEFIT LIMITATIONS

Maryland Physicians Care does not cover these services except where noted and the State does not cover these services.

- Services performed before the effective date of the member's enrollment in the MCO are not covered by the MCO but may be covered by Medicaid fee-for-service if the member was enrolled in Medicaid;
- Services that are not medically necessary;
- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state);
- Services that are beyond the scope of practice of the health care practitioner performing the service;
- Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when a member is participating in an authorized clinical trial;
- Cosmetic surgery to improve appearance or related services, but not including surgery and related services to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental abnormalities;

- While enrolled in an MCO, services, except for emergency services, are not covered when the member is outside the State of Maryland unless the provider is part of Maryland Physicians Care network. Services may be covered when provided by an MCO network provider who has obtained the proper referral or pre-authorization if required. If a Medicaid beneficiary is not in an MCO on the date of service, Medicaid fee-for service may cover the service if it is a covered benefit and if the out of state provider is enrolled in Maryland Medicaid;
- Services provided outside the United States;
- Immunizations for travel outside the U.S.;
- Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis;
- Private hospital room is not covered unless medically necessary or no other room is available;
- Autopsies;
- Private duty nursing services for adults 21 years old and older;
- Orthodontia is not covered by the MCO but may be covered by Healthy Smiles when the member is under 21 and scores at least 15 points on the Handicapping Labio-lingual Deviations Index No. 4 and the condition causes dysfunction;
- Ovulation stimulants, in vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar;
- Reversal of voluntary sterilization procedures;
- Medications for the treatment of sexual dysfunction;
- MCOs are not permitted to cover abortions. We are required to assist members in locating these services and we are responsible for related services (sonograms, lab work, but the abortion procedure, when conditions are met, must be billed to Medicaid fee-for service;
- Non-legend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the member is under 12 years old and non-legend drugs other than insulin and enteric-coated aspirin for arthritis;
- Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;
- Diet and exercise programs for weight loss except when medically necessary;
- Lifestyle improvements (physical fitness programs and nutrition counseling, unless specified); and
- MCOs do not cover emergency transportation services and are not required to cover non-emergency transportation services (NEMT). Maryland Physicians Care will assist members to access non-emergency transportation through the local health department. We will provide some transportation if necessary to fill any gaps that may temporarily occur in our network.
    - Maryland Physicians Care will assist members to secure non-emergency transportation through their local Health Departments. Additionally, we provide non-emergency transportation to access a covered service if we choose to provide the service at a location that is outside of the closest county in which the service is available.

Section IV

PRIOR AUTHORIZATION
AND
MEMBER COMPLAINT, GRIEVANCE
AND APPEAL PROCEDURES

Services Requiring Prior Authorization

All non-emergency elective hospital admissions require prior authorization.

All oncology and radiation oncology services require prior authorization and must have an Eviti Code prior to submitting the Prior Authorization request. Please contact Provider Services regarding access to our current oncology and radiation oncology services vendor at www.eviti.com.

After the initial evaluation, rehabilitative and habilitative therapy services, including those rendered by Chiropractors, require prior authorization. Services rendered in a hospital emergency department, observation unit, or inpatient unit; in an acute rehabilitation hospital; or in a skilled nursing facility do not require authorization. Please contact National Imaging Associates (NIA) prior to or within 5 business days of rendering services. NIA can be reached at www.RadMD.com or via NIA's call center at (800) 424-4836.

Certain non-emergent outpatient cardiac procedures require prior authorization. These services include CT/CTA, MRI/MRA, PET Scan, CCTA, Myocardial Perfusion Imaging, Multigated Acquisition (MUGA) Scan, Stress Echocardiography, and Echocardiography (TTE/TEE). Cardiologists may receive authorizations by contacting NIA at www. RadMD.com or via NIA's call center at (800) 424-4836. Approved authorizations will have a validity period of 60 days from the date of request.

Prior authorization is required for high tech radiology and non-emergent musculoskeletal procedures including outpatient, interventional spine pain management services. These authorizations are obtained through NIA at www.RadMD.com or via NIA's call center at (800) 424-4836.

Maryland Physicians Care requires laboratory and radiology services to be done in free-standing (non-regulated) facilities. Authorization will be required for services performed in hospital/facility (regulated) space. Certain radiology and laboratory services may require prior authorization regardless of place of service.

Following the recommendation by the U.S. Preventive Services Task Force, MPC covers 2-D mammograms for its members and 3D diagnostic mammograms only with prior authorization. MPC policy reimburses claims submitted for a 2D screening mammogram using CPT 77067. For providers billing 3D screening mammograms, providers can submit claim with the 2D CPT code, and the add-on code. The 3D screening add-on code 77063 will be denied as a non-covered service, and only the CPT 77067 will be reimbursed. Providers with members who accept financial responsibility for the 3D add-on code, CPT 77063, before the rendered service may bill members for the 3D portion of the claim. Please remember this financial responsibility form is specific to the service and is not the general financial responsibility form. Providers without a signed financial responsibility form for the 3D add-on code may not balance bill Medicaid members. MPC policy will reimburse a 3D diagnostic mammogram only when an approved prior authorization is obtained for this service.

Maryland Physicians Care (MPC) requires certain medications to be administered in free-standing (non-regulated) infusion facilities or via home infusion. These medications are normally administered by a healthcare provider via infusion or injection. Authorization will be required for infusion services of these medications administered in a hospital/facility (regulated) space. Most medications administered under the medical benefit require prior authorization regardless of place of service.

Maryland Physicians Care requires all defined CMS outpatient procedures to be rendered in an Ambulatory Surgical Center (ASC). Authorization will be required for services performed in hospital/facility (regulated) space. Certain procedures require prior authorization regardless of place of service.

Outpatient hospitals or facility-based surgical services may require prior authorization.

Durable medical equipment, homecare, therapy, and hospice require prior authorization.
To see which procedures require prior authorization, access the Pre-Auth Check tool on the Maryland Physicians Care website under the Providers section.

Laboratory - Members are to be referred to a participating free-standing laboratory provider for services not in the Participating Specialist Provider (PSP's)/PCP's contract. All laboratory services performed outside Maryland Physicians Care's laboratory network require Prior Authorization. Laboratory and certain radiology services may not be performed in a hospital setting.

Non-participating providers must obtain prior authorization before rendering any service other than emergency services. Participating providers must obtain prior authorization before rendering any service that is not exempt from prior authorization requirements. **Services that require prior authorization may be denied if prior authorization has not been obtained.**

Registered network providers may perform electronic look-up of a prior authorization through the employment of Maryland Physicians Care's HIPAA-compliant web portal.

Hospice and Respite services are covered but require prior authorization.

Services Not Requiring Preauthorization

Procedures performed in the PCP's, OBS's or PSP's office do not require prior authorization.

Contracted providers are not required to request prior authorization for any procedures that are specified in of their Maryland Physicians Care Provider Agreement.

PSPs with a valid referral from the member's PCP, may not be required to obtain prior authorization for procedures that are performed in office.

Radiology procedures may be performed by PCPs and PCOs as defined in their Maryland Physicians Care provider contract. PSPs may perform radiology procedures in office without Prior Authorization, except as defined in the Maryland Physicians Care Provider Agreement.

Prior authorizations procedures

Prior authorization is one of the tools by which Maryland Physicians Care monitors the medical necessity and cost-effectiveness of the health care members receive. Participating and nonparticipating health professionals, hospitals, and other providers are required to comply with Maryland Physicians Care's prior authorization policies and procedures. Noncompliance may result in delay or denial of reimbursement.

Prior authorization review includes:

- Verification that the member is enrolled with Maryland Physicians Care on the date of service and at the time of the request for authorization
- Verification that the requested service is a covered benefit for the member under the HealthChoice Program
- Assessment of the requested service's medical necessity based on Maryland Physicians Care medical review criteria
- Verification that the service is being provided by a contracted provider and in the appropriate setting

Requesting prior authorization

Requests for prior authorization are to be directed to Maryland Physicians Care's prior authorization (PA) department.

- To ensure a timely response to your request, submit all prior authorization requests at least 14 days in advance with all required information.
- A prior authorization request must include the following:
    - Name, date of birth, gender, and identification number of the member
    - Current, applicable codes which may include: Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes, National Drug Code (NDC)
    - Diagnosis code: International Classification of Diseases, ICD-10 CODES
    - Name, phone and fax number of the referring/ordering practitioner or provider
    - NPI/TIN of referring/ordering practitioner or provider
    - Name, phone and fax number of the servicing practitioner or provider (place of service)
    - NPI/TIN of servicing practitioner or provider
    - Reason for the request
    - Number of units requested for each code
    - Clinical information including but not limited to: supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request.

If a member receiving emergency department treatment requires emergent inpatient care, the provider facility will notify the Prior Authorization department within one business day of the inpatient admission. The Prior Authorization department will document the notification. For elective or direct admissions, the provider must contact the Prior Authorization department for an authorization prior to the admission. Reimbursement for services during admission is based on concurrent review. Providers should note that lack of notification within one business day may result in an administrative denial.

Registered network providers may perform electronic look-up of a prior authorization through the employment of Maryland Physicians Care's HIPAA-compliant web portal.

Inpatient Admissions and Concurrent Review

All non-emergency elective hospital admissions require prior authorization.
The concurrent review function provides a way to evaluate admissions while a member is hospitalized. Admissions are reviewed for medical necessity, and continuing services are evaluated for the appropriate use of inpatient medical resources.

Services subject to concurrent review include but are not limited to those provided in acute and specialty hospitals, rehabilitation, and skilled nursing facilities, including inpatient hospice care.

Services provided to MPC members are reviewed for appropriateness, efficiency, and timeliness. Failure to provide services timely may result in denials for the delay in service.

When a MPC member is admitted to a facility, the provider is required to send a formal notification to the Prior Authorization department within one business day. Clinical information must then be sent to the Utilization Management department within 24 hours of that notification.

Participating hospitals, where an observation facility stay transitions to an inpatient admission, are required to notify Maryland Physicians Care within one business day of the admission.

Admissions to non-par facilities are reviewed for medical necessity based on MPC's provider network ability to provide the same services. All requests for admission to non-par facilities require prior authorization by calling Maryland Physicians Care. Any member who presents to a non-par provider through the emergency room must be transferred to a par provider as soon as stabilized. Any member transferred from a provider to a non-par provider with prior authorization must be transferred back to a par provider as soon as is stabilized.

The admitting or treating provider is responsible for complying with MPC's concurrent review requirements, policies, and procedures and making the following information available for concurrent review:

- Name, date of birth, gender, and identification number of the member
- Current, applicable codes which may include: Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes, National Drug Code (NDC)
- Diagnosis code: International Classification of Diseases, ICD-10 CODES
- Name, phone, and fax number of the referring/ordering practitioner or provider
- NPI/TIN of referring/ordering practitioner or provider
- Name, phone, and fax number of the servicing practitioner or provider (place of service)
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request
- The following is the minimum clinical information that must be received for a complete medical necessity review to be performed
- The mode of presentation (home, ER, direct, transfer, elective), the current presenting complaints, including clinical signs and symptoms, past medical history, the working diagnosis, tests, labs, consults ordered and the results, treatment plan, medications, discharge plans, including any social concerns

Maryland Physicians Care uses nationally recognized, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. For inpatient medical care reviews, Maryland Physicians Care uses the following medical review criteria:

- Criteria required by applicable state or federal regulatory agency
- Applicable InterQual Criteria as the primary decision support for most medical diagnoses and conditions
- Maryland Physicians Care Clinical Policy Guidelines

All adverse determinations of service requests will be reviewed and rendered by a medical director except for administrative denials. Administrative adverse determinations are denials of coverage for services that are based on reasons other than clinically based rationale and do not require a medical director review.

Examples of administrative adverse determinations include:

- The individual is not a member at the time of service

- An excluded benefit
- Breach of contract, e.g. when Maryland Physicians Care's contract requires notification of an admission within a specified timeframe and no notification/clinical is received

Authorization requests that do not meet criteria for the requested service, or for which there are no established medical necessity criteria will be presented to a medical director for review. The medical director conducting the review will have clinical expertise in treating the member's condition or disease and will be qualified by training, experience, and certification/licensure to conduct the authorization functions in accordance with state and federal regulations.

The medical director will review the service request, the member's need, and the clinical information presented. Using the approved criteria and the medical director's clinical judgment, a determination to approve or deny the service will be made. Only a medical director can reduce or deny a request for service based on a medical necessity review. The UM decision-making criteria is available upon request.

Should you like to obtain a copy, you can contact MPC's Utilization Department by calling 800-953-8854 and follow the prompts to the Customer Service Department.

Peer to Peer Requests
The Peer-to-Peer Process is available to any provider who is rendered a denial. The intent of the Peer-to-Peer is to discuss the denial decision. To request a peer to peer regarding a denial, call 410-412-8297 and leave the following information:

- Provider name
- Provider phone number
- Member name
- Member DOB
- Authorization #
- Provider's available date and time(s)
- The caller's contact information

The provider/facility must request the peer-to-peer within two business days of the initial notification of the denial. Any clinical information provided will need to be faxed to 877-535-0591.

Period of preauthorization

Prior authorization numbers are valid for the date of service authorized or for a period not to exceed **60** days after the date of service authorized. The member must be eligible for Medicaid and enrolled in Maryland Physicians Care on each date of service. For information about how to verify member eligibility, refer to the State Eligibility Verification system (EVS) https://encrypt.emdhealthchoice.org/emedicaid/.

Hospital Transfer and Stabilization

Maryland Physicians Care participating hospital facilities must transfer to a participating hospital facility. If the participating transferring hospital is unable to transfer to a participating facility, notification to Maryland Physicians Care is required within one business day of the transfer.

Out-of-network non-participating acute care facilities who receive transferred patients are responsible to notify Maryland Physicians Care within one business day of a direct transfer admission.

Transfers received through the emergency department must notify Maryland Physicians Care within one business day of hospital admission. Stabilization and post-stabilization must be coordinated following Maryland Physicians Care's concurrent review process. Concurrent and peer review process must be followed to define patient stabilization. Upon patient stabilization, out of network facilities are obligated to coordinate with Maryland Physicians Care to transfer the member to an in-network facility.

Prior authorization and coordination of benefits

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

Medical Necessity Criteria

A "medically necessary" service or benefit must be:

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

Clinical Guidelines

Maryland Physicians Care uses nationally recognized, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. For inpatient medical care reviews, Maryland Physicians Care uses the following medical review criteria:

- Criteria required by applicable state or federal regulatory agency
- Applicable InterQual Criteria as the primary decision support for most medical diagnoses and conditions Maryland Physicians Care Clinical Policy Guidelines

Timeliness of Decisions and Notifications to Providers and Members

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

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

Maryland Physicians Care will send notice to deny authorizations to providers and members:

- Standard authorizations - within 72 hours from the date of determination
- Expedited authorizations - within 24 hours from the date of determination

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Maryland Physicians Care will assign a prior authorization number, which refers to and documents the approval. Maryland Physicians Care sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request. Refer to Section I for list of self-referred services which are services we must allow members to access out-of- network. Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Maryland Physicians Care makes such decisions on a case-by-case basis.

Overview of Member Complaint, Grievance and Appeal Processes

Our MCO member services line, 1-800-953-8854**,** operates Monday through Friday from 8 a.m. to 5 p.m. Member services resolves or properly refers members' inquiries or complaints to the State or other agencies. Maryland Physicians Care informs members and providers of the grievance system processes for complaints, grievances, appeals, and Maryland State Fair Hearings. This information is contained in the Member Handbook and is available on the Maryland Physicians Care website at MarylandPhysiciansCare.com.

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

Members and their representatives may also request any of the following information from Maryland Physicians Care, free of charge, to help with their appeal by calling 1-800-953-8854:

- Medical records;
- Any benefit provision, guideline, protocol, or criterion Maryland Physicians Care used to make its decision;
- Oral interpretation and written translation assistance; and
- Assistance with filling out Maryland Physicians Care's appeal forms.

Maryland Physicians Care will take no punitive action for:

- Members requesting appeals or grievances;
- Providers requesting expedited resolution of appeals or grievances;
- Providers supporting a member's appeal or grievance; or
- Members or providers making complaints against Maryland Physicians Care or the Department.

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

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

MCO Member Grievance Procedures

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

review programs applying drug utilization review standards.

Examples of reasons to file an administrative grievance include:

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

Examples of reasons to file a medical grievance include:

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

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

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

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

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

MCO Member Appeal Procedures

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

- Maryland Physicians Care denies covering a service ordered or prescribed by the member's provider. The reasons a service might be denied include:
    - The treatment is not needed for the member's condition, or would not help you in diagnosing the member's condition.
    - Another more effective service could be provided instead.

    - The service could be offered in a more appropriate setting, such as a provider's office instead of the hospital.
- Maryland Physicians Care limits, reduces, suspends, or stops a service that a member is already receiving. For example:
    - The member has been getting physical therapy for a hip injury and they have reached the frequency of physical therapy visits allowed.
    - The member has been prescribed a medication, it runs out, and they do not receive any more refills for the medication.
- Maryland Physicians Care denies all or part of payment for a service a member has received, and the denial was not related to the claim being "clean".
- Maryland Physicians Care fails to provide services in a timely manner, as defined by the Department (for example, it takes too long to authorize a service a member or their provider requested).
- Maryland Physicians Care denies a member's request to speed up (or expedite) the resolution about a medical issue.

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

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

If the member wants to file an appeal with Maryland Physicians Care, they have to file it within 60 days from the date of the denial letter. Our denial letters must include information about the HealthChoice Help Line. If the member has questions or needs assistance, direct them to call 1-800-284-4510. Providers may call the State's HealthChoice Provider Help Line at 1-800-766-8692. If you would like to appeal a decision on a member's behalf, you must obtain the member's consent to appeal in writing and submit it to us.

When the member files an appeal, or at any time during our review, the member and/or provider should provide us with any new information that will help us make our decision. The member or representative may ask for up to 14 additional days to gather information to resolve the appeal. If the member or representative needs more time to gather information to help Maryland Physicians Care make a decision, they may call Maryland Physicians Care at 1-800-953-8854 and ask for an extension.

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

When reviewing the member's appeal, we will:

- Use doctors with appropriate clinical expertise in treating the member's condition or disease;
- Not use the same MCO staff to review the appeal who denied the original request for service; and
- Make a decision within 30 days, if the member's ability to attain, maintain, or regain maximum function is

not at risk.

On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where a member's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the member's condition cannot be adequately managed without urgent care or services. Maryland Physicians Care resolves expedited appeals effectively and efficiently as the member's health requires. Written confirmation or the member's written consent is not required to have the provider act on the member's behalf for an expedited appeal. If the appeal needs to be reviewed quickly due to the seriousness of the member's condition, and Maryland Physicians Care agrees, the member will receive a decision about their appeal as expeditiously as the member health condition requires or no later than 72 hours from the request. If an appeal does not meet expedited criteria, it will automatically be transferred to a standard timeframe. Maryland Physicians Care will make a reasonable effort to provide verbal notification and will send written notification within two (2) calendar days.

Once we complete our review, we will send the member a letter letting them know our decision. Maryland Physicians Care will send written notification for a standard appeal timeframe, including an explanation for the decision, **within 2 business days of the decision.**

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

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

Request to Continue Benefits During the Appeal

If the member's appeal is about ending, stopping, or reducing a service that was authorized, they may be able to continue to receive the service while we review their appeal. Providers may not request to continue benefits on the member's behalf. The member must contact us within 10 days of receiving the denial notice at 1-800-953-8854 if they would like to continue receiving services while their appeal is reviewed. The service or benefit will continue until either the member withdraws the appeal or the appeal or fair hearing decision is adverse to the member. If the member does not win their appeal, they may have to pay for the services that they received while the appeal was being reviewed.

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

State Fair Hearing Rights

A HealthChoice member may exercise their State Fair Hearing rights but the member must first file an appeal with Maryland Physicians Care. If Maryland Physicians Care upholds the denial the member may appeal to the Office of Administrative Hearings (OAH) by contacting the HealthChoice Help Line at 1-800-284-4510. If the member decides to request a State Fair Hearing we will continue to work with the member and the provider to attempt to resolve the issue prior to the hearing date.

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

State HealthChoice Help Lines

If a member has questions about the HealthChoice Program or the actions of Maryland Physicians Care direct them to call the State's HealthChoice Help Line at 1-800-284-4510. Providers can contact the HealthChoice Provider Line at 1-800-766-8692.

Section V.

PHARMACY MANAGEMENT

Pharmacy Benefit Management

Maryland Physicians Care is responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. prescription medications and certain over-the-counter medicines. 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, a decision will be provided within 24 hours of request. When a prescriber believes that a non-formulary drug is medically indicated, we have procedures in place for non-formulary requests. The State expects a non-formulary drug to be approved if documentation is provided indicating that the formulary alternative is not medically appropriate. Requests for non-formulary drugs will not be automatically denied or delayed with repeated requests for additional information.

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

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

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

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

Maryland Physicians Care contracts with CVS Caremark to provide the following services: pharmacy network contracting and network Point-of-Sale (POS) claim processing.

Mail Order Prescriptions

Maryland Physicians Care does not currently offer mail-order pharmacy services but there are instances when delivery for certain drugs is possible.

Specialty Pharmacy Services

For specialty pharmacy services Maryland Physicians Care does not mandate the use of any specific specialty pharmacy; therefore, our members may use any of the numerous specialty pharmacies within our network.

Maryland Physicians Care is responsible for formulary development, drug utilization review, and prior authorization. Maryland Physicians Care's drug utilization review program is subject to review and approval by MDH and is coordinated with the drug utilization review program of the Behavioral Health Service delivery system.

Prescription and Drug formulary

Check the current Maryland Physicians Care formulary, via our website at: MarylandPhysiciansCare.com, before writing a prescription for either prescription or over-the-counter drugs Maryland Physicians Care members must have their prescriptions filled at a network pharmacy.

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

Prescription Copays

There are no copays for children under 21, pregnant members, people of Native American heritage, individuals in a nursing facility or hospice, or for family planning. The Maryland Department of Health mandates that other HealthChoice members have up to a $3 copayment for non-preferred brand-name drugs and up to $1 copayment for generic, preferred, and HIV/AIDS drugs. Maintenance medications that are on the MPC 90-day supply list will also be $1 for preferred/generic and $3 for non-preferred/brand medications.

Over- the-Counter Products

Some over-the-counter (OTC) products are covered according to the Maryland Physicians Care OTC list and will require a prescription.

Injectables and Non-Formulary Medications Requiring Prior-Authorization

Most Specialty Medications require prior authorization. Providers can fax the alternate fax form used for prior authorization request to 1-866-207-7231 for the Maryland Physicians Care Pharmacy Prior Authorization department to process. Prior authorization forms can be downloaded from the Maryland Physicians Care website at: MarylandPhysiciansCare.com.

Prior Authorization Process

Medication coverage may be subject to preauthorization to ensure medical necessity for specific therapies. Some medications are covered by both the pharmacy benefit and medical benefit. which have different processes for prior authorization. Please refer to Maryland Physicians Care covered drug list to determine which entity will review the medication.

- Pharmacy Benefit Medications: Medications listed here are normally dispensed via retail or specialty pharmacy and are administered by the patient or caregiver. For drugs requiring preauthorization under the pharmacy benefit, providers can submit an electronic prior authorization or fax a prior authorization request form to 1-833-896-0656. The prior authorization request forms can be downloaded from the Maryland Physicians Care website at: MarylandPhysiciansCare.com. The MPC pharmacy team can be reached by phone at 1-888-258-8250.

- Medical Benefit Medications: Medications listed here are normally "buy and bill" and are administered by a healthcare professional in a hospital, office or infusion setting. For drugs requiring preauthorization under the medical benefit, providers can submit an electronic prior authorization or fax a prior authorization request form to 1-800-953-8856. The prior authorization request forms can be downloaded from the Maryland Physicians Care website at: MarylandPhysiciansCare.com. The MPC Medical team can be reached by phone at 1-800-953-8854.

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

Step Therapy and Quantity Limits

The Step Therapy (ST) program requires certain first-line drugs (generic drugs or other formulary drugs) be prescribed prior to approval of specific second-line drugs. If the prerequisite first-line agents have been filled and treatment failure has occurred, the member will be able to fill the prescription automatically, and it will need to be determined if a prior authorization is required.

Maryland Physicians Care authorizes a maximum of 30 days' supply of all medications. A review for vacation and lost medications overrides can be reviewed as needed by plan.

Maryland Prescription Drug Monitoring Program

Maryland Physicians Care complies with the Maryland Prescription Drug Monitoring Program. The Maryland Prescription Drug Monitoring Program (PDMP) is an important component of the Maryland Department of Health initiative to halt the abuse and diversion of prescription drugs. The Maryland Department of Health is a statewide database that collects prescription data on Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH) dispensed in outpatient settings. The Maryland Department of Health does not collect data on any other drugs.

Pharmacies must submit data to the Maryland Department of Health at least once every 15 days. This requirement applies to pharmacies that dispense CDS or HGH in outpatient settings in Maryland, and by out-of-state pharmacies dispensing CDS or HGH into Maryland. Patient information in the Maryland Department of Health is intended to help prescribers and pharmacists provide better-informed patient care. The information will help supplement patient evaluations, confirm patients' drug histories, and document compliance with therapeutic regimens.

New registration access to the Maryland Department of Health database at https://crisphealth.org/services/prescription-drug-monitoring-program-pdmp/pdmp-registration/ is granted to prescribers and pharmacists who are licensed by the State of Maryland and in good standing with their respective licensing boards. Prescribers and pharmacists authorized to access the Maryland Department of Health, must certify before each search that they are seeking data solely for the purpose of providing healthcare to current patients. Authorized users agree that they will not provide access to the Maryland Department of Health to any other individuals, including members of their staff.

Corrective Managed Care Program

We restrict members to one pharmacy if they have abused pharmacy benefits. We must follow the State's criteria for Corrective Managed Care. The Corrective Managed Care (CMC) Program is an ongoing effort by the Maryland Medicaid Pharmacy Program (MMPP) to monitor and promote appropriate use of controlled substances. Call 1-800-953-8854 if a member is having difficulty filling a prescription. The CMC program is particularly concerned with appropriate utilization of opioids and benzodiazepines. Maryland Physicians Care will work with the State in these efforts and adhere to the State's Opioid preauthorization criteria.

Maryland Opioid Prescribing Guidance and Policies

The following policies apply to both Medicaid Fee-for-Service and all 9 Managed Care Organizations (MCO):

Policy

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

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

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

Guidance:

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

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

Screening, Brief Intervention and Referral to Treatment (SBIRT), is an evidenced-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and drugs. The practice has proved successful

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

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

[3] A description of these substance use screening tools may be accessed at: http://www.integration.samhsa.gov/clinical-practice/screening-tools

in hospitals, specialty medical practices, emergency departments and workplace wellness programs. SBIRT can be easily used in primary care settings and enables providers to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work or family issues.

The provision of SBIRT is a billable service under Medicaid. Information on billing may be accessed here: https://mmcp.health.maryland.gov/MCOupdates/Documents/pt_43_16_edicaid_program_updates_for_spring_2016.pdf

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

Providers should use the PMDP every time they write a prescription for CDS. Administered by MDH, the PDMP gives healthcare providers online access to their patients' complete CDS prescription profile. Practitioners can access prescription information collected by the PDMP *at no cost* through the CRISP health information exchange, an electronic health information network connecting all acute care hospitals in Maryland and other healthcare facilities. Providers that register with CRISP get access to a powerful "virtual health record" that includes patient hospital admission, discharge and transfer records, laboratory and radiology reports and clinical documents, as well as PDMP data.

For more information about the PDMP, visit the MDH website: https://health.maryland.gov/pdmp/pages/home.aspx If you are not already a registered CRISP user you can register for **free** at https://crisphealth.force.com/crisp2_login. PDMP usage is highly encouraged for all CDS prescribers and will become mandatory to check patients CDS prescriptions if prescribing CDS at least every 90 days (by law).

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

Section VI.

CLAIMS SUBMISSION, PROVIDER APPEALS, QUALITY INITIATIVES, PROVIDER PERFORMANCE DATA AND PAY FOR PERFORMANCE

Facts to Know Before You Bill

Provider Revalidation and Enrollment Portal (ePREP)

You must verify through the Eligibility Verification System (EVS) that participants are assigned to Maryland Physicians Care before rendering services.

All rendering and billing providers must enroll and maintain active enrollment in Maryland Department of Health electronic Provider Revalidation and Enrollment Portal (ePREP) in accordance with Maryland Department of Health requirement. Failure to maintain an active status with ePREP may result in claim denials or termination from the network.

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

Submitting Claims to Maryland Physicians Care

Providers are required to submit electronic or paper claims to Maryland Physicians Care 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. For a claim on a UB 04 claim form, one hundred eighty (180) days is counted from the date of discharge for the hospital or nursing home stay. Claims that are not initially received within one hundred eighty (180) days of the date of service may be denied for payment.

When Maryland Physicians Care is secondary, claims with other coverage may be submitted to Maryland Physicians Care up to six months from the other coverage remittance advice date and within 18 months from the date of service. The claim must be submitted with the other coverage remittance advice.

Maryland Physicians Care **prefers to receive electronic claims via a Maryland Physicians Care approved Electronic Data Interchange (EDI) vendor.** Please contact your Provider Services Representative for further information on electronic claims or for a list of approved EDI vendors. After Maryland Physicians Care has adjudicated a claim, you will receive a Remittance Advice with the reimbursement, which will provide details about the submitted claim and its status.

Paper Claim Submission
All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. If a paper claim has been rejected, provider should submit the rejection letter with the corrected claim.

Maryland Physicians Care only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper claims forms. Other claim form types will be upfront rejected and returned to the provider. Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Maryland Physicians Care does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10 or 12 Times New Roman font and on the required original red and white version to ensure clean acceptance and processing. Black and white, nonstandard and forms with handwriting will be upfront rejected and returned to provider. To reduce document handling time, do not use highlights, italics, bold text, or staples for multiple page submissions. If you have questions regarding what type of form to complete, contact Provider Services.

Please mail paper claims to:
Maryland Physicians Care MCO Claims
PO Box 21099
Eagan, MN 55121

Emergency Department Facility Claims
Hospitals may initially submit paper claims for emergency department services with the attachment of medical records to support review and reimbursement for all emergency services. Please mail these paper claims with medical records to:
Maryland Physicians Care MCO Claims
PO Box 21099
Eagan, MN 55121

Hospitals may submit the claim without medical records for review and reimbursement of including EMTALA/prudent layperson services. A claim review will be completed and services meeting these requirements will be reimbursed. Additional medical records may be required for further review of services, including ancillary services determined to be medically necessary to rule out or confirm an emergent condition. Hospitals may obtain a copy of Maryland Physicians Care “auto pay” list on the website.

Hospital Outpatient Facility Stays
All hospital, participating and non-participating are allowed up to 24 hours observation stay without authorization. MDH HealthChoice program allows up to 24 hours observation stay for reimbursement. There are no appeals and exceptions to this policy.

Hospitals, where an observation facility stay transitions to an inpatient admission, are required to notify Maryland Physicians Care within one (1) business day of the admission.

Hospitals that bill for an inpatient admission and subsequently submit a corrected claim for an observation stay may require additional documentation to support the change of order occurred prior to any inpatient stay claim denial. If the order for change from inpatient to observation stay is entered in the medical record before the claim paid date, date of adjudication, then the appeal for claim denial of the observation stay will be considered. If the change in

order from inpatient to observation stay or a corrected claim for outpatient occurs after the claim paid date, date of adjudication, then the claim denial will be upheld.

Hospitals that bill the observation stay with the inpatient admission may be required to submit additional documentation as part of the review of the admission. Hospitals may bill the observation stay as an outpatient facility bill.

Provider Overpayment Refunds

Federal and State regulations require providers to routinely audit claims for overpayments. Medicaid funds that were improperly paid or overpaid must be returned within 60 days of discovery. If your practice determines it has received an overpayment or improper payments, you are required to return the overpayment to Maryland Physicians Care within 60 calendar days after the date the overpayment was identified and notify MPC in writing of the reason for the overpayment.

Overpayments should be returned along with the reason for the overpayment and a copy of the Explanation of Payment(s) to:

ADDRESS:
Maryland Physicians Care
P.O. Box 22655
New York, NY 10087-2655

Billing inquiries

Providers may contact Maryland Physicians Care's Provider Services Claims department, to check the status of claims submitted for reimbursement, clarify any denials or other claim processing actions. Provider Services can be reached at 1-800-953-8854; registered network providers may also perform claims inquiry through the Maryland Physicians Care's secure web portal.

A corrected or resubmission of a prior claim is not considered an appeal and will not be treated as such. For claim resubmissions, including a response to an invalid or incomplete claim submission and/or a claim resubmission with previously missing claim information, submitters have 90 calendar days from the date of denial to file a timely resubmission request via EDI or to the following address:

Maryland Physicians Care
P.O. Box 1104
Portland, ME 04104

Provider Appeal of Maryland Physicians Care Claim Denial or Reimbursement

Maryland Physicians Care has a process regarding provider appeals as a request for a review of an action related to claims denials or disputes. Providers must appeal claims disputes following Maryland Physicians Care's provider claim appeal process exhausting all levels of appeal, as appropriate unless exclusively mutually agreed upon in writing, by provider and Maryland Physicians Care. Appeals for service denials, reductions or terminations of services are considered member appeals, and follow the MCO member appeal process described in the Member appeal section of this manual.

A provider appeal must be submitted in writing either by:

FAX: 833-656-0648
or
MAIL:
Maryland Physicians Care
PO Box 1104
Portland, ME 04104

Timeframes related to the appeals process are:

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

Emergency Department Claims Appeals

When submitting an appeal for emergency facility claims, hospitals must indicate which medically necessary services are being requested for review and reimbursement in order to rule out or confirm an emergent condition.
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Program Integrity - Hospital Claim Reviews

- Maryland Physicians Care is required to audit reimbursement to providers which include hospital billing audits for financial and procedural accuracy and review of appropriateness of services to prevent overuse and abuse of services. These reviews include services provided by professional and facilities.

- Maryland's Health Services Cost Review Commission (HSCRC) sets Maryland Hospital Rates as part of their hospital rate application and cost review regulations. MD MCOs (including MPC) pay MD Hospitals for medically necessary and plan eligible approved services at the HSCRC approved hospital rates to which MD hospitals bill charges, less regulatory approved Medicaid, GME or prompt payment discounts allowed.

- Maryland Medicaid and its participating Managed Care Organization for its HealthChoice program, are required to ensure all hospital services are appropriate for reimbursement via payment and post payment reviews to ensure proper payment for all services of its programs. Those reviews do not include the rate of the payment rather proper payment of plan covered services. Submitted facility charges are reviewed for the determination of plan covered services and non-covered charges.

- COMAR 10.67. 07 - Program Integrity requires review of appropriate payment of services, including acute inpatient services. Maryland hospitals are to bill all services at its approved HSCRC rates (via its annual rate application process) to which appropriately billed services are reimbursed and reviewed for appropriateness via standard CMS/MDH and industry standard review processes. These processes are also included in our Hospital agreement as required by MDH, CMS and government programs. MPC has not contractually waived the application of these industry standard review processes and plan benefit/ covered charge references per the terms of the Participating Health Provider Agreement.

Maryland Physicians Care will not take any punitive action against a provider for utilizing our provider complaint process.

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

State's Independent Review Organization (IRO)

The Department contracts with an IRO for the purpose of offering providers another level of appeal for providers who wish to appeal **medical necessity denials** only. Providers must first exhaust all levels of the MCO appeal process. By using the IRO, you agree to give up all appeal rights (e.g., administrative hearings, court cases). The IRO only charges **after** making the case determination. If the decision upholds the MCO's denial, you must pay the fee. If the IRO reverses the MCO's denial, the MCO must pay the fee. The web portal will walk you through submitting payments. The review fee is $425 More detailed information on the IRO process can be found at https://mmcp.health.maryland.gov/SitePages/IRO%20Information.aspx .The IRO does not accept cases for review which involve disputes between the Behavioral Health ASO and Maryland Physicians Care**.**

MCO Quality Initiatives

Maryland Physicians Care focuses on collaboration with network provider to provide quality services to our members. We continually evaluate and monitor medical care and member programs to assess delivery of care to our members' and identify opportunities for improvement.

Annually, Maryland Physicians Care assesses our programs' progress against set goals. All aspects of the Quality Improvement Program are evaluated, including clinical and service activities. Some of these activities include:

- Assuring the quality of network providers by adherence to industry standards for credentialing
- Assessing provider availability to ensure members have access to qualified health care professionals through monitoring network adequacy against established standards
- Promoting safety in healthcare through member and provider education
- Publishing Preventive Health Guidelines and Clinical Practice Guidelines to establish medical service expectations aligned with industry standards
- Evaluating the quality of care members receive through analysis of measure outcomes, known as, Healthcare Effectiveness Data and Information Set (HEDIS®)
- Measuring outcomes to determine whether our members are receiving appropriate preventive care, such as:
    - Annual flu shots
    - Child immunizations (shots)
    - Eye tests
    - Cholesterol tests
    - Prenatal care for pregnant members
- Investigating member quality of care concerns and taking action, if necessary
- Conducting both member and provider annual surveys to assess levels of satisfaction with Maryland Physicians Care services

Provider Performance Data

Practitioners will cooperate with Quality Improvement (QI) activities, maintain the confidentiality of member information and records as well as allow the plan to use the provider performance data.

Section VII.

PROVIDER SERVICES AND RESPONSIBILITIES

Overview of Maryland Physicians Care Provider Services

Maryland Physicians Care's Provider Services Department works collaboratively with Maryland Physicians Care network providers, the EDI Team and Maryland Physicians Care Operations to ensure the successful management of EDI claims submissions.

Important points to remember

- Maryland Physicians Care pays the clearinghouse costs.
- Maryland Physicians Care does not require EDI registration of its providers. All that is required is that the provider submits claims through one of the above-referenced contracted clearing houses in the appropriate format.
- Maryland Physicians Care does not accept direct EDI submissions from its providers.
- Maryland Physicians Care does not perform any 837 testing directly with its providers, but performs such testing with its contracted clearinghouses.
- Providers submitting claims directly through a *contracted clearinghouse* should not be charged a per-claim cost. Providers using an interim clearinghouse to get to a Maryland Physicians Care contracted clearinghouse may be charged a per-claim cost.
- An 837 Companion Guide is available for your reference and convenience.

Provider Web Portal

Our enhanced, secure and user-friendly web portal is now available. This HIPAA-compliant portal is available 24 hours a day and it supports the functions and access to information that you need to take care of your patients. Popular features include:

- Easily check patient eligibility
- View, manage, and download your patient list
- View claims
- View and submit service authorizations
- Communicate with us through secure messaging
- Maintain multiple providers on one account
- Control website access for your office

Provider Inquiries

For provider inquires please contact Provider Services at 1-800-953-8854 or you may contact your Provider Relations Representative directly. For your convenience, you can find the current Provider Territory list on our website at: MarylandPhysiciansCare.com

Re-Credentialing

Maryland Physicians Care requires re-credentialing at a minimum of every 3 years because it is essential that we maintain current provider professional information.

Overview of Provider Responsibilities

1) PCP shall verify the enrollment and assignment of the Member via Maryland Physicians Care's secure online web portal prior to the provision of Covered Services. Failure to verify Member enrollment may result in claim denial.

2) PCP shall provide or arrange for medically necessary Covered Services to Members as defined herein, including Emergency Medical Services, on a twenty-four (24) hour-per-day basis, seven (7) days per week.

3) PCP shall 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. Member should be given the choice of waiting or rescheduling the appointment.

4) Practitioners shall provide the same hours of operation for Medicaid members as those for non-Medicaid members. 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 or institutional providers, 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.

5) PCP shall coordinate the provisions of Covered Services to Members by (a) counseling Members and their families regarding Member's medical care needs, including family planning and advance directives; (b) initiating referrals of Members for specific Covered Services to Participating Health Professionals, Hospitals and Providers and MDH Specialty Mental Health System; and, (c) monitoring progress of Member's care and coordinating utilization of services to facilitate the return of Member's care to the PCP as soon as appropriate.

6) PCP shall maintain staff membership and admission privileges in good standing at one of the hospitals with which Maryland Physicians Care has contracted as a Participating Hospital unless specifically authorized by Maryland Physicians Care.

7) PCP shall admit Members in need of hospitalization only to participating hospitals unless: (1) prior authorization for admission to some other facility has been obtained from Maryland Physicians Care or (2) the Member's condition is emergent and use of a participating hospital is not feasible for medical reasons. The PCP agrees to provide covered services to Members while in a hospital as determined medically necessary by the PCP or Maryland Physicians Care's Medical Director.

8) PCP shall maintain a current DEA and CDS number throughout the term of this agreement and Maryland Physicians Care encourages the PCP to record DEA and CDS number on all prescriptions.

9) 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.

10) PCP shall have a free and clear license, and report any changes in status of licensure to Maryland Physicians Care's Provider Services Department immediately upon receipt of notification of change of license status.

11) PCP shall provide preventive health services in accordance with MDH Rules and Regulations and MCO medical policies. The preventive health services shall include but not be limited to:

    a) Periodic health assessments for all assigned Members twenty-one (21) years of age and over that includes major medical, social history and family history within a two-year time frame;

    b) Immunizations and tuberculosis screening (but not immunizations solely for travel), and other measures for the prevention and detection of disease including instruction in personal health care

measures and information on proper and timely use of appropriate medical resources pursuant to Maryland Physicians Care's medical policy provided by or through the MCO; and

c) Early and Periodic Screening Diagnosis and Treatment (EPSDT) for all assigned Members up to the age of twenty-one (21) years. This includes the MDH EPSDT periodicity schedule, tracking forms, and specific Primary Mental Health services for certain eligible Members. All PCP's that care for members age 21 and younger are encouraged to obtain EPSDT certification from the state of Maryland.

12) PCP shall prescribe and authorize the substitution of generic pharmaceuticals and agrees to abide with Maryland Physicians Care Drug Formulary.

13) PCP shall 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.

14) PCP shall offer a referral to the specialized case management program upon diagnosis or identification of a Member with HIV/AIDS. If the Member refuses the referral, the PCP shall continue to provide case management services. The Member may request, and be granted, a referral to case management services at any time following his/her diagnosis. The PCP shall offer the Member who has HIV/AIDS an annual Diagnostic and Evaluation Service (DES) visit and document the Member's acceptance or declination in the Member's medical record.

15) PCP shall make a referral to Maryland Physicians Care case management staff department and submit a completed Maryland's Confidential Morbidity Report to the Local Health Officer at the Local Health Department (LHD) upon diagnosis or identification of a member living with HIV/AIDS. PSP shall cooperate with the case manager, and notify Maryland Physicians Care of any substantial changes in the member's status.

16) PCP shall not refer or direct Members to hospital emergency departments for Non-Emergent Medical Services at any time during the term of this Agreement. PCP shall
make a concerted effort to educate and instruct Members about the proper utilization of the PCP office in lieu of hospital emergency departments.

17) PCP shall initiate and follow up appropriate referrals for Special Needs Population (children with special care needs, individuals with a physical or developmental disability, pregnant and postpartum members , individuals who are homeless, and individuals with HIV/AIDS) and for all Members. PCPs shall be responsible for bringing Members into compliance with medical treatment plan. MCO will work with PCP to facilitate the appointment scheduling process using the following schedule guidelines for:

a) Children under two years of age, PCP shall continue to contact the Member's parent or guardian to reschedule appointments within thirty (30) days of a missed appointment for the first three (3) missed appointments and within sixty (60) days of any additional reschedule appointments thereafter.

b) A child between the ages of two and twenty-one with a diagnosed condition requiring follow-up, the PCP shall contact the Member or parent/guardian to reschedule appointments within thirty (30) days of a missed appointment for the first two (2) missed appointments of any additional rescheduled appointments thereafter.

c) A pregnant woman who has completed her initial visit but has not kept a follow-up appointment, the PCP will contact the Member to reschedule appointments within ten (10) days of a missed appointment for the first three (3) missed appointments and within thirty (30) days of any additional appointments thereafter. Obstetrician Specialist (OBS) shall maintain responsibility for care for sixty (60) days after delivery with a minimum of one (1) postpartum visit at approximately (6) weeks postpartum or within ten (10) days of request. Specifically, the postpartum visit must be performed between 21 to 56 days after the delivery.

18) PCP shall schedule time-specific appointments for:

a) New members initial appointment within ninety (90) days of the date of their enrollment unless the provider determines that no immediate initial appointment is necessary if the member already has an established relationship with the provider. For those members who are children under the age of two (2) years old needing EPSDT screening services, appointments will be in accordance with the EPSDT periodicity schedule or within thirty (30) days of receipt of the MDH health risk assessment, whichever is less. PCPs shall report to Maryland Physicians Care, which assigned members have not made an initial appointment at thirty (30), sixty (60) and ninety (90) day intervals.

b) New members, within ten (10) days of Maryland Physicians Care's identification of a pregnant Member, or of Maryland Physicians Care receiving the completed health risk assessment for a new member who is pregnant, or within the (10) days of when a pregnant Member fails to keep her appointment, the PCP shall reschedule the appointment within ten (10) days.

c) Well child assessments within thirty (30) days of request.

d) Initial prenatal or postpartum visits within ten (10) days of Member's request or within ten (10) days of MCO identification, or within ten (10) days of the date of receipt of a completed MDH health risk assessment, whichever is sooner.

e) Family planning visits within ten (10) days of request.

f) Urgent care within forty-eight (48) hours.

g) Routine and preventive primary care within thirty (30) days of request.

h) On the same day for emergency care.

i) If a Member is pregnant or diagnosed with HIV/AIDS and is identified as a substance abuser, the PCP will refer the Member for substance use disorder treatment within twenty-four (24) hours of the Member's request or identification.

j) Initial newborn visit within fourteen (14) days of discharge if no home visit has occurred; within thirty (30) days of discharge if a home visit has occurred. Home visits are required within 36 hours of discharge when discharge occurs within forty-eight (48) hours of delivery.

k) If new members are identified as high risk by the MDH health risk assessment, Maryland Physicians Care will notify the PCP to schedule an initial appointment within fifteen (15) days of the receipt of the member's completed MDH health risk assessment.

l) ER visit follow-up, if required, within seventy-two (72) hours.

19) PCP shall adhere to Maryland Physicians Care managed care philosophy and principles, and to participate as active Members on MCO standing committees.

20) PCP shall utilize current CPT Coding guidelines including HCPCS.

21) PCP shall adhere to practice guidelines contained within Maryland Physicians Care's Reproductive Health and Wellness Policies as per MDH outlined on their website.

22) 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.

23) PCP shall conduct a substance use disorder screening using a formal substance use disorder screening tool, such as the CAGE-AID (CAGE Adapted to Include Drugs), appropriate for the detection of both alcohol and drug abuse, and appropriate to the age of the patient as part of each Member's initial appointment and baseline physical, and at future appointments as indicated by the Member's behavior when the member's physical status, including laboratory findings, indicates the likelihood of substance use disorder.

    Based on the substance use disorder screening findings, the PCP will refer Members identified as being in need of substance use disorder treatment to an Alcohol and Drug Abuse Administration certified substance use disorder treatment center for a comprehensive substance abuse assessment. As determined by comprehensive assessment results, the Member will be offered substance use disorder treatment services at a level of care using American Society of Addiction Medicine Patient Placement Criteria.

24) PCP shall comply with the Patient Self-Determination Act (effective December 1, 1991).

25) PCP shall abide by and follow Maryland Physicians Care's medical record standards for specialists outlined in Medical Records Standards section of this manual.

26) PCP is responsible for identifying those Members requiring mental health services. Individuals in need of specialty mental health services will be referred to the MDH Specialty Mental Health System.

27) PCP shall not bill Maryland Physicians Care members for covered services, missed appointments, or medical records. The PCP may also not bill Maryland Physicians Care for medical records.

28) PCP may not bill the Program/MCO or the recipient for completion of forms and reports; broken or missed appointments, or professional services rendered by mail or telephone.

29) PCP must inform the member prior to treatment that the service is not a covered benefit, with regard to billing Maryland Physicians Care members for non-covered services. The PCP must obtain a signed waiver specific to the service being rendered to memorialize that the Maryland Physicians Care member is aware that the service is not a covered benefit. The PCP must make or inform the Maryland Physicians Care member of available payment arrangements for the non-covered service.

Participating Specialist Providers (PSP)

1) Under the general direction of the PSP, covered services shall be offered to members in accordance with customary standards of practice. Covered services refer to those services available to members pursuant to HealthChoice regulations and Maryland Physicians Care related policies and procedures.

2) PSP shall provide covered services to members pursuant to Maryland Physicians Care prior authorization and referral policy. Failure to comply with these policies may result in claim denial.

3) Practitioners shall provider the same hours of operation for Medicaid members as those for non-Medicaid members. PSP agrees to use its best efforts to ensure that a Member's waiting time at the PSP's office shall not exceed sixty (60) minutes, unless the PSP is of the delay and providing the Member with the option to either wait or reschedule.

   PSP shall verify member enrollment prior to the provision of covered services. Failure to verify such enrollment may result in claim denial. **PSP should verify the eligibility and effective date with Maryland Physicians Care by accessing "My MPC Source," our secure online web portal, at MarylandPhysicianCare.com.**

4) PSP shall provide urgent care appointments within forty-eight (48) hours of member's request. Routine care appointments shall be provided by PSP within sixty (60) days of member's request.

5) PSP shall provide or arrange for medically necessary Covered Services to Members as defined herein, including Emergency Medical Services, on a twenty-four (24) hour-per-day basis, seven (7) days per week.

6) PSP shall refer members to participating health professionals in accordance with Maryland Physicians Care's prior authorization and referral policy. The PSP will maintain documentation of referrals, including feedback and outcome of the referrals.

7) PSP shall maintain a current DEA and CDS number. Maryland Physicians Care encourages each PSP to record the DEA and CDS numbers on all prescriptions.

8) PSP shall maintain free and clear licensure, and report any change in status of licensure to Maryland Physicians Care's Provider Services Department immediately upon receipt of notification of licensure status change.

9) PSP shall prescribe or authorize the substitution of generic pharmaceuticals and agrees to abide with Maryland Physicians Care's drug formulary.

10) PSP shall render services to members who are diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC) in the same manner and to the extent as other Members.

11) PSP shall maintain staff membership and admission privileges in good standing at a participating hospital unless specifically authorized by Maryland Physicians Care.

12) PSP shall admit members in need of hospitalization only to participating hospitals unless (1) prior authorization for admission to some other facility has been obtained from Maryland Physicians Care, or (2) the member's condition is emergent and use of a participating hospital is not feasible for medical reasons.

13) PSP agrees to provide covered services to members while in a hospital as determined medically necessary by the PSP or Maryland Physicians Care Medical Director.

14) PSP shall not intentionally refer or direct members to hospital emergency departments for non-emergent medical services at any time during the term of the Agreement. PSP shall make a concerted effort to educate and instruct members about the proper access of routine specialty care (via office visits) in lieu of hospital emergency departments.

15) PSP shall identify those Members requiring substance abuse services. Individuals in need of substance abuse services will be referred to the MDH Specialty Substance Abuse System.

16) PSP shall adhere to Maryland Physicians Care's managed care philosophy and principles, including the sharing of relevant medical information with the member's assigned Primary Care Provider.

17) PSP shall utilize current CPT coding guidelines, including HCPCS.

18) PSP shall bring referred members into compliance with medical treatment plans. Maryland Physicians Care will work with PSP to facilitate appointment scheduling in the event of an access issue.

19) PSP shall comply with the Patient Self-Determination Act (effective December 1, 1991).

20) PSP shall abide by and follow Maryland Physicians Care's policies and procedures, including quality management and utilization management.

21) PSP shall abide by and follow Maryland Physicians Care's medical record standards for specialists outlined in Medical Records Standards section of this manual.

22) PSP shall provide medical or surgical services within the scope of his specialty practice to members in accordance with applicable HealthChoice Program rules and regulations and Maryland Physicians Care policies and procedures.

23) PSP shall not assign covered services to any other specialist provider unless that provider has been credentialed and approved by Maryland Physicians Care as a PSP under this Agreement.

24) PSP shall make a referral to Maryland Physicians Care case management staff department and submit a completed Maryland's Confidential Morbidity Report to the Local Health Officer at the Local Health Department (LHD) upon diagnosis or identification of a member living with HIV/AIDS. PSP shall cooperate with the case manager, and notify Maryland Physicians Care of any substantial changes in the member's status.

25) The PSP shall refer the member living with HIV/AIDS for an annual Diagnostic and Evaluation Service (DES) visit and document the member's acceptance or declination in the member's medical record.

26) PSP shall comply with Occupational Safety and Health Administration regulation of and including, without limitation, those concerning Blood borne pathogens standards (29 C.F.R. Part 1910.1030 effective January 1, 1992).

27) PSP shall identify those Members requiring mental health services. Individuals in need of specialty mental health services will be referred to the MDH Specialty Mental Health System.

28) PSP shall not bill Maryland Physicians Care members for covered services, missed appointments, or medical records. The PSP may also not bill Maryland Physicians Care for medical records.

29) PSP shall not bill the Program/MCO or the recipient for completion of forms and reports, broken or missed appointments, or professional services rendered by mail or telephone.

30) PSP must inform the member prior to treatment that the service is not a covered benefit with regard to billing Maryland Physicians Care members for non-covered services. The PSP must obtain a signed waiver specific to the service being rendered to memorialize that the Maryland Physicians Care member is aware that the service is not a covered benefit. The PSP must make or inform the Maryland Physicians Care member of available payment arrangements for the non-covered service.

Participating Obstetrician Specialist (OBS)

Role of the OBS

1) Under the general direction of the OBS, covered services shall be offered to members in accordance with customary standards of practice. Covered services refer to those services available to members pursuant to HealthChoice regulations and Maryland Physicians Care related policies and procedures.

2) OBS shall provide or arrange for Covered Services to Members as defined herein, including emergency Medical Services, on a twenty-four (24) hour per day basis, seven (7) days per week.

3) OBS shall ensure that a member's waiting time at the OBS's office shall exceed sixty (60) minutes, unless the OBS is unavailable due to an emergency. The member should be given the choice of waiting or rescheduling the appointment.

4) OBS shall provide to members (a) office visits during regular 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 or institutional providers; (b) office visits, or home visits or other appropriate visits during non-office hours as determined medically necessary; and (c) shall answer telephone 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.

5) OBS shall coordinate the provision of covered services to members by (a) counseling members and their families regarding a member's medical care needs, including family planning and advance directives; (b) initiating referrals of members for specific Covered Services to Participating Health Professionals, Hospitals and Providers and the MDH Specialty Mental Health System; and (c) monitoring progress of the member's care and coordinating utilization of services to facilitate the return to the OBS twenty-one (21) to fifty-six (56) days after delivery.

6) OBS shall maintain staff membership and admission privileges in good standing at one of the hospitals with which Maryland Physicians Care MCO has contracted as a Participating Hospital unless specifically authorized by Maryland Physicians Care MCO.

7) OBS shall admit members in need of hospitalization only to Participating Hospitals unless (1) prior authorization for admission to some other facility has been obtained from Maryland Physicians Care MCO or (2) the member's condition is emergent and use of a Participating Hospital is not feasible for medical reasons.

The OBS agrees to provide Covered Services to members while in the hospital as determined medically necessary by the OBS or Maryland Physicians Care MCO Medical Doctor.

8) OBS shall maintain a current DEA and CDS number throughout the term of this Agreement. MCO encourages OBS to record DEA and CDS numbers on all prescriptions.

9) OBS shall be licensed and have training and experience in obstetrics/gynecology, may be Board-Certified, have completed and approved training program, or be generally recognized by the provider community as being skilled in obstetrical/gynecological practice.

10) OBS shall maintain free and clear licensure, and shall report any changes in licensure status to Maryland Physicians Care's Provider Services Department immediately upon receipt of notification of licensure status change.

11) OBS shall prescribe and authorize the substitution of generic pharmaceuticals and agrees to abide by the Maryland Physicians Care MCO Drug Formulary.

12) OBS shall 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 under the compensation terms set forth herein.

13) OBS shall offer a referral to the specialized case management programs upon diagnosis or identification of a member with HIV/AIDS. If the member refuses, the OBS will continue to provide case management services. The member may request, and be granted, a referral to case management services at any time following her diagnosis.

14) OBS shall offer members with HIV/AIDS an annual Diagnostic Evaluation Service (DES) assessment and documenting whether the member accepts or declines the assessment.

15) OBS shall not refer or direct members to hospital emergency departments for non-emergent medical services at any time during the term of this Agreement. OBS shall make a concerted effort to educate and instruct members about the proper utilization of the OBS office in lieu of hospital emergency departments. If hospital emergency department utilization exceeds Maryland Physicians Care MCO determined standards of acceptance, Maryland Physicians Care MCO may deduct or recoup payments from OBS.

16) OBS shall bring members into compliance with medical treatment plans. The OBS shall make provisions and schedule time-specific medically necessary care appointments for enrolled pregnant members to obtain initial and ongoing prenatal care. Maryland Physicians Care MCO will work with OBS to facilitate the appointment scheduling process using the following guidelines:

- Within ten (10) days of Maryland Physicians Care MCO's identification of a pregnant member or of Maryland Physicians Care MCO receiving the completed health risk assessment (*prenatal risk assessment for pregnant members)* PRA, or within then (10) days of when the member requested an appointment, whichever is earlier. If a pregnant member fails to keep her initial appointment, the OBS shall reschedule the appointment within thirty (30) day intervals of a missed appointment for the first three (3) missed appointments and notify Maryland Physicians Care MCO of each missed appointment.
- For a pregnant woman who has completed her initial visit but has not kept a follow-up appointment, the OBS will contact the member to reschedule appointments within ten (10) days of a missed appointment for the first

three (3) missed appointments, and within thirty (30) days of any additional rescheduled appointments thereafter.

- First trimester – within ten (10) days of a request for an appointment.
- Second trimester – within seven (7) days of a request for an appointment.
- Third trimester – within three (3) days of a request for an appointment.
- High-risk prenatal care shall be initiated within three (3) business days of identification or immediately, if an emergency exists.
- Patients at high risk shall have a return-visit schedule appropriate to their individual need.
- ER visits, follow-up if required, within seventy-two (72) hours.
- Urgent care within forty-eight (48) hours.
- On the same day for emergency care.
- Postpartum care after delivery, between 21 and 56 days.

17) OBS shall schedule time-specific office visits during an uncomplicated pregnancy based upon the following recommended standards promulgated by the American College of Obstetrics and Gynecology (ACOG):

- Every four (4) weeks for the first twenty-eight (28) weeks of pregnancy;
- Every two (2) – three (3) weeks until thirty –six (36) weeks of gestation; and weekly thereafter.

18) OBS shall maintain responsibility for care for sixty (60) days after delivery with a minimum of one (1) postpartum visit at **postpartum** or within ten (10) days of request. **Specifically, the postpartum visit must be performed on or between twenty-one (21) and fifty-six (56) days after delivery.**

19) OBS or Primary Care Practitioner must complete a prenatal risk assessment (PRA) using Maryland Physicians Care MCO screening form, at the first prenatal visit and forward the completed form to the Local Health Department and the Maryland Physicians Care Prior Authorization department.

20) OBS shall conduct a substance use disorder screening using a formal substance use disorder screening tool, such as the CAGE-AID (CAGE Adapted to Include Drugs), appropriate for the detection of both alcohol and drug abuse, and appropriate to the age of the patient as part of each member's initial appointment and baseline physical, and at future appointments as indicated by the member's behavior when the member's physical status, including laboratory findings, indicates the likelihood of substance use disorder. If the member is identified as being in need of substance use disorder treatment, or the member requests substance use disorder treatment, the OBS will refer the member for substance use disorder treatment within twenty-four (24) hours of the requirement or identification. Members identified, as being at risk for substance use disorder will be offered a more detailed screening/assessment. The OBS shall identify the most appropriate level of care for the member.

21) OBS shall adhere to MCO managed care philosophy and principles, and to participate as active members on MCO standing committees.

22) OBS shall utilize current CPT Coding Guidelines, including HCPCS.

23) OBS shall adhere to practice guidelines contained within MCO Reproductive Health and Wellness Policies.

24) OBS 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.

25) OBS shall comply with the Patient Self-Determination Act (effective December 1, 1991).

26) OBS shall abide by and follow Maryland Physicians Care's medical record standards for specialists, outlined in the Medical Records Standards section of this manual.

Primary Care Providers (PCPs)

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

The PCP is required to:

- Address the member's general health needs;
- Treat illnesses;
- Coordinate the member's health care;
- Promote disease prevention and maintenance of health;
- Maintain the member's health records; and
- Refer for specialty care when necessary.

If a woman's PCP is not a women's health specialist, Maryland Physicians Care will allow her to see a women's health specialist within the Maryland Physicians Care network without a referral, for covered services necessary to provide women's routine and preventive health care services. Prior authorization is required for certain treatment services.

PCP Contract Terminations

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

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

Specialty Providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. MDH requires Maryland Physicians Care to maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits. If a PCP cannot locate an appropriate specialty provider, call 1-800-953-8854 for assistance.

Use of specialty network providers will be reviewed for:

- Medical necessity
- Availability of timely access (within 6 weeks) at a network provider

- Consideration for continued care at the specialty network provider is dependent on diagnosis and condition of the member
- Availability of a medically necessary service not currently available in the network

Requests for services at a non-network/specialty network provider will be redirected to a network provider unless there is no clinical expertise available within the network for the presenting case.

If the request is a post-service review for services provided by a non-participating/specialty network provider, Maryland Physicians Care will deny unless the clinical supports emergent or urgent care.

If Maryland Physicians Care approves an alternative to the service being requested and the treating practitioner or member does not agree to the alternative service, the Maryland Physicians Care will issue a denial for the care that was originally requested. However, if the treating practitioner agrees with the alternative and the care is authorized, the practitioner has essentially withdrawn the initial request which is not considered a denial.

Physician Assistant
Maryland Physicians Care allows Physician Assistants to service members however; the claims must be submitted under the supervising Physician as the rendering provider.

Out of Network Providers and Single Case Agreements

Non-participating providers must obtain prior authorization before rendering any service other than emergency services. **Services that require prior authorization may be denied if prior authorization has not been obtained.**

Providers interested in becoming a participating provider, please visit our website at www.MarylandPhysiciansCare.com. You will find the Letter of Interest under the Join Our Network tab.

A Single Case Agreement is a contract between Maryland Physicians Care and an out-of-network provider for a specific patient, so that the patient can see that provider using their in-network benefits. The rate that will be paid is negotiated by Maryland Physicians Care and the provider as part of the Single Case Agreement.

Single Case Letters of Agreement may be used to support network development initiatives and,

- To obtain medical care for members in areas that lack contracted providers.
- To obtain specialized covered services and/or equipment that contracted providers are not able to provide/perform.
- To reduce the cost of transporting members long distances to a participating provider for care.

Requests for letters of agreement may be initiated by Maryland Physicians Care's Prior Authorization and/or Medical Management Department.

Second Opinions

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

Provider Requested Member Transfer

When persistent problems prevent an effective provider-patient relationship, a participating provider may ask a member to leave their practice. Such requests cannot be based solely on the member filing a grievance, an appeal, a

request for a Fair Hearing or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

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

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

Maryland Physicians Care
Provider Relations Department
1201 Winterson Road, 4th Floor
Linthicum, MD 21090

- The provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care.

- Upon request, the provider will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

For questions or additional information please contact Provider Services at 1-800-953-8854.

Medical Records Requirements

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 Maryland Physicians Care provider network.

1. 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.
2. Confidentiality – Records are kept confidential in accordance with HIPAA requirements.
3. Patient Identification – Each page in the medical record must contain patient name or patient identification number.
4. 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.
5. 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.
6. Entry Date – All entries must be dated.
7. Legible – The medical record must be legible to someone other than the writer.
8. Problem List – Significant and/or chronic illnesses and medical conditions should be indicated on the problem list.
9. 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.
10. 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.
11. 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.

12. Personal Habits (for patients seen three or more times) – Notation concerning use of tobacco products, sexual behavior, and history of alcohol and substance use disorder for patients age 12 and older.
13. Physical Exam (Complete) – All body systems to be reviewed within two years of first clinical encounter. HEENT (lungs, neck, heart, neuro back and extremities).
14. Height, weight, blood pressure, temperature, and Body Mass Index (BMI) – Must be documented, as applicable, at the initial health assessment and subsequent visits as indicated.
15. History and Physical – Subjective and objective information is obtained and noted for the presenting complaints. Children and Adolescent well checks should include an assessment and documentation of physical and mental development.
16. Working Diagnosis – Working diagnosis is consistent with findings (provider's medical impression).
17. Plan/Treatment – Documentation of the recommended treatment plan that is consistent with the diagnoses.
18. Continuity of Care – Unresolved problems from the previous visit are addressed in the subsequent visit.
19. Patient Education/Instructions – Documentation includes patient instruction regarding significant findings, changes in treatment plan and medications. Children and Adolescent Well-Care visits require documentation of health education and anticipatory guidance provided during the visit.
20. 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.
21. 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.
22. 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.
23. 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 Maryland Physicians Care's designated Medical Director for further direction.
24. Immunization Record –
    - For all adult members age 21 and older, records must indicate patient's immunization status for TB.
    - For all members age 21 and over and at high risk* (See Adult Immunization Guidelines), record must indicate immunization status for influenza, pneumococcal and/or hepatitis B.
    - For members under age 21, there must be a complete immunization record documented. If there is no record, a notation regarding immunization status by history should be documented (i.e.: UTD per Member). Attempts to obtain records must be documented and followed up. Re-immunization must be considered for all school-age children without vaccine records of at least one of each vaccine.
25. Preventive Services (for adult members seen three or more times) – Record should indicate preventive services are offered according to Maryland Physicians Care's Adult Screening Guidelines for Asymptomatic Men and Women.
26. For Maryland Managed Medicaid program members under age 21, preventive health services must be provided according to the Maryland Physicians Care Pediatric Preventive Guidelines, which are the same as the Healthy Kids (EPSDT schedule).
27. 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 the response is "Yes", it is recommended that a copy be requested for the medical record.

28. Maryland Physicians Care required forms – Maryland Physicians Care 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.
29. 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.
30. Alcohol/Substance Screening – On the initial visit, the Member must be screened for alcohol and substance-use disorder as part of the initial health assessment. The Michigan Alcohol Screening Test (MAST), CAGE or comparable tool can be used for screening purposes.

Medical Record Standards for Specialists and OBS

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 (QARD) as the minimum, acceptable standards within Maryland Physicians Care's provider network.

1. **Organization** – Medical records must be organized systematically and uniformly to allow for efficient and rapid review. Papers must be firmly attached. Individual unit medical records are required as opposed to family medical records.
2. **Confidentiality** – Records are kept confidential in accordance with HIPAA requirements.
3. **Patient Identification** – Each page in the medical record must contain patient name or patient identification number.
4. **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.
5. **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.
6. **Entry Date** – All entries must be dated.
7. **Legible** – The medical record must be legible to someone other than the writer.
8. **Referring Provider/PCP** – The referring provider and the reason for the visit must be identifiable – this may be through a copy of the referral form in the chart or other reference.
9. **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.
10. **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.
11. **Past Medical History** – Past medical history should be documented relative to the presenting problem.
12. **Physical Exam Findings** –A targeted physical examination relative to the reason for referral must be completed and documented. Abnormal exam findings must be described.
13. **History and Physical** – Subjective and objective information is obtained and noted for the presenting complaints.
14. **Working Diagnosis** – Working diagnosis is consistent with findings (provider's medical impression).
15. **Plan/Treatment** – Documentation of the recommended treatment plan that is consistent with the diagnosis and the reason for the referral.
16. **Patient Education/Instructions** – Documentation is present regarding treatment options, treatment changes (i.e. medications, dietary restrictions, etc.) and preventive care, as indicated.
17. **Lab Tests, X-rays and Diagnostic Tests** – Results of ordered tests are present in the medical record and initialed by the ordering provider. Abnormal lab, imaging study and other diagnostic study results must have an explicit notation in the medical record of follow-up plans.

18. **Follow-up/Return Visits** – Encounter forms or notes indicate the follow-up interval. Return intervals for the PCP vs. the specialist is specified. Instruction regarding when to follow up with the PCP versus the specialist should be documented. On discharge, the member is referred back to the PCP.
19. **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 Maryland Physicians Care's designated Medical Director for further direction. Specifically, the reviewer notes any issues with necessity, timeliness or duplication of services.
20. **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.
21. **Correspondence/Communication with PCP** – There is evidence that the findings and recommendations from the consult were communicated to the PCP. Abnormal test results in need of follow-up are communicated to the PCP. Phone calls to the PCP are made and documented regarding urgent medical needs or significant findings, as indicated.
22. **Maryland Physicians Care required forms** – Maryland Physicians Care 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, Maryland Prenatal Risk Assessment Forms, etc.
23. **Outreach/Non-compliance –** There is documentation of compliance/non-compliance with the medical care plan. Missed appointments are documented in the medical record. For specialists, there is at least one outreach attempt documented for all missed appointments and then communication to the PCP regarding the lack of follow-up.

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

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

The medical record facilitates:

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

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

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

Confidentiality and Accuracy of Member Records

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

Providers must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations (http://www.hhs.gov/ocr/privacy/).

Reporting Communicable Disease

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

- The provider report must identify the disease or suspected disease and demographics on the member including the name age, race, sex and address of residence, hospitalization, date of death, etc. on a form provided by the Department (DHMH1140) as directed by COMAR 10.06.01.
- With respect to patients with tuberculosis, you must:
  - Report each confirmed or suspected case of tuberculosis to the LHD within 48 hours.
  - Provide treatment in accordance with the goals, priorities, and procedures set forth in the most recent edition of the Guidelines for Prevention and Treatment of Tuberculosis, published by MDH.

Advance Directives

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

- Providing written information to adult members regarding each individual's rights under Maryland law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections);
- Documenting in the member's medical record, whether or not the adult member has been provided the information and whether an advance directive has been executed;
- Not discriminating against a member because of their decision to execute or not execute, an advance directive and not making it a condition for the provision of care;
- Educating staff on issues related to advance directives, as well as communicating the member's wishes to attending staff at hospitals or other facilities; and
- Educate patients on Advance Directives (durable power of attorney and living wills).
- Encourage patients to utilize electronic advance care planning documents.
- MCOs are required to make the Advance Directives Information Sheet available during enrollment and in member publications, on their website, and at the member's request.

Advance directive forms and frequently asked questions can be found at:
www.marylandattorneygeneral.gov/Pages/HealthPolicy/advancedirectives.aspx

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

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

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

Cultural Competency

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

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

Health Literacy – Limited English Proficiency (LEP) or Reading Skills

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

Access for Individuals with Disabilities

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

Treatment of Minors

In accordance with Maryland Code, Health-General § 20-102 (c), a minor has the same capacity as an adult to consent to:

(1) Treatment for or advice about drug abuse;
(2) Treatment for or advice about alcoholism;
(3) Treatment for or advice about venereal disease;
(4) Treatment for or advice about pregnancy;
(5) Treatment for or advice about contraception other than sterilization;
(6) Physical examination and treatment of injuries from an alleged rape or sexual offense;
(7) Physical examination to obtain evidence of an alleged rape or sexual offense; and
(8) Initial medical screening and physical examination on and after admission of the minor into a detention center.

Section VIII.

QUALITY ASSURANCE MONITORING PLAN
AND
REPORTING FRAUD, WASTE, AND ABUSE

Quality Assurance Monitoring Plan

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

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

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

To report these measures to MDH, Maryland Physicians Care must perform chart audits throughout the year to collect clinical information on our Members. Maryland Physicians Care truly appreciates the provider offices' cooperation when medical records are requested.

In addition to information reported to MDH, Maryland Physicians Care collects additional quality information. Providers may need to provide records for standard medical record audits that ensure appropriate record documentation. Our Quality Improvement staff may also request records or written responses if quality issues are raised in association with a member complaint, chart review, or referral from another source.

Fraud, Waste, and Abuse Activities

Maryland Physicians Care has a Fraud, Waste and Abuse workgroup with designees from each department to review compliance activities which include but are not limited to compliance referrals, fraud case discussion, audit and monitoring activities, Special Investigation Unit case investigations and sanctioned and excluded providers.

Reporting Suspected Fraud and Abuse

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

All Medicaid program providers are required to report suspected fraud or abuse (a requirement which can be subject to federal or state sanctions) by contacting Maryland Physicians Care's Compliance Hotline at 1-866-781-6403, or visiting Maryland Physicians Care's website at **MarylandPhysiciansCare.com.** Launch on "Fraud" and you can email us suspected fraud information. Please furnish as much of the information listed below to support Maryland Physicians Care's completing a thorough investigation of the suspected fraud and abuse.

- Your name
- Name of the Maryland Physicians Care member or provider you suspect of fraud
- Member's Maryland Physicians Care card number
- Name of doctor, hospital or other health care provider
- Date of service
- Amount of money that Maryland Physicians Care paid for service
- Description of the acts you suspect involve fraud or abuse**.**

You can also report provider fraud to the MDH Office of the Inspector General at **410-767-5784 or 1-866-770-7175**), the Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General, at **410-576-6521** (**1-888-743-0023**) or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS (1-800-447-8477).**

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

Relevant Laws

There are several relevant laws that apply to Fraud, Waste, and Abuse:

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

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

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a Federal health care program.

Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

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

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

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

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

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

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

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

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

- Denial or revocation of Medicare or Medicaid provider number application (if applicable);
- Suspension of provider payments;
- Being added to the OIG List of Excluded Individuals/Entities database; or
- License suspension or revocation.

Remediation may include any or all of the following:

- Education;
- Administrative sanctions;
- Civil litigation and settlements;
- Criminal prosecution;
- Automatic disbarment; or
- Prison time.

Exclusion Lists & Death Master Report

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

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

Additional Resources:

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

Attachments

ATTACHMENT I

RARE AND EXPENSIVE CASE MANAGEMENT (REM) PROGRAM

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

Medicaid Benefits and REM Case Management

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

The participant's REM case manager will:

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

Referral and Enrollment Process

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

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

For questions and referral forms call 800-565-8190; forms may be faxed to 410-333-5426 or mailed to:
REM Intake Unit
Maryland Department of Health
201 W. Preston Street, Room 210
Baltimore, MD 21201-2399

Table of Rare and Expensive Diagnosis

ICD10	ICD 10 Description	AGE LIMIT
B20	Human immunodeficiency virus (HIV) disease	0-20
C96.0	Multifocal and multisystemic Langerhans-cell histiocytosis	0-64
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis	0-64
C96.6	Unifocal Langerhans-cell histiocytosis	0-64
D61.01	Constitutional (pure) red blood cell aplasia	0-20
D61.09	Other constitutional aplastic anemia	0-20
D66	Hereditary factor VIII deficiency	0-64
D67	Hereditary factor IX deficiency	0-64
D68.0	Von Willebrand's disease	0-64
D68.1	Hereditary factor XI deficiency	0-64
D68.2	Hereditary deficiency of other clotting factors	0-64
E70.0	Classical phenylketonuria	0-20
E70.1	Other hyperphenylalaninemias	0-20
E70.20	Disorder of tyrosine metabolism, unspecified	0-20
E70.21	Tyrosinemia	0-20
E70.29	Other disorders of tyrosine metabolism	0-20
E70.30	Albinism, unspecified	0-20
E70.40	Disorders of histidine metabolism, unspecified	0-20
E70.41	Histidinemia	0-20
E70.49	Other disorders of histidine metabolism	0-20
E70.5	Disorders of tryptophan metabolism	0-20
E70.8	Other disorders of aromatic amino-acid metabolism	0-20
E71.0	Maple-syrup-urine disease	0-20
E71.110	Isovaleric acidemia	0-20
E71.111	3-methylglutaconic aciduria	0-20
E71.118	Other branched-chain organic acidurias	0-20
E71.120	Methylmalonic acidemia	0-20
E71.121	Propionic acidemia	0-20
E71.128	Other disorders of propionate metabolism	0-20
E71.19	Other disorders of branched-chain amino-acid metabolism	0-20
E71.2	Disorder of branched-chain amino-acid metabolism, unspecified	0-20
E71.310	Long chain/very long chain acyl CoA dehydrogenase deficiency	0-64
E71.311	Medium chain acyl CoA dehydrogenase deficiency	0-64
E71.312	Short chain acyl CoA dehydrogenase deficiency	0-64
E71.313	Glutaric aciduria type II	0-64
E71.314	Muscle carnitine palmitoyltransferase deficiency	0-64
E71.318	Other disorders of fatty-acid oxidation	0-64
E71.32	Disorders of ketone metabolism	0-64
E71.39	Other disorders of fatty-acid metabolism	0-64
E71.41	Primary carnitine deficiency	0-64
E71.42	Carnitine deficiency due to inborn errors of metabolism	0-64
E71.50	Peroxisomal disorder, unspecified	0-64
E71.510	Zellweger syndrome	0-64

E71.511	Neonatal adrenoleukodystrophy	0-64
E71.518	Other disorders of peroxisome biogenesis	0-64
E71.520	Childhood cerebral X-linked adrenoleukodystrophy	0-64
E71.521	Adolescent X-linked adrenoleukodystrophy	0-64
E71.522	Adrenomyeloneuropathy	0-64
E71.528	Other X-linked adrenoleukodystrophy	0-64
E71.529	X-linked adrenoleukodystrophy, unspecified type	0-64
E71.53	Other group 2 peroxisomal disorders	0-64
E71.540	Rhizomelic chondrodysplasia punctata	0-64
E71.541	Zellweger-like syndrome	0-64
E71.542	Other group 3 peroxisomal disorders	0-64
E71.548	Other peroxisomal disorders	0-64
E72.01	Cystinuria	0-20
E72.02	Hartnup's disease	0-20
E72.03	Lowe's syndrome	0-20
E72.04	Cystinosis	0-20
E72.09	Other disorders of amino-acid transport	0-20
E72.11	Homocystinuria	0-20
E72.12	Methylenetetrahydrofolate reductase deficiency	0-20
E72.19	Other disorders of sulfur-bearing amino-acid metabolism	0-20
E72.20	Disorder of urea cycle metabolism, unspecified	0-20
E72.21	Argininemia	0-20
E72.22	Arginosuccinic aciduria	0-20
E72.23	Citrullinemia	0-20
E72.29	Other disorders of urea cycle metabolism	0-20
E72.3	Disorders of lysine and hydroxylysine metabolism	0-20
E72.4	Disorders of ornithine metabolism	0-20
E72.51	Non-ketotic hyperglycinemia	0-20
E72.52	Trimethylaminuria	0-20
E72.53	Primary Hyperoxaluria	0-20
E72.59	Other disorders of glycine metabolism	0-20
E72.81	Disorders of gamma aminobutyric acid metabolism	0-20
E72.89	Other specified disorders of amino-acid metabolism	0-20
E74.00	Glycogen storage disease, unspecified	0-20
E74.01	von Gierke disease	0-20
E74.02	Pompe disease	0-20
E74.03	Cori disease	0-20
E74.04	McArdle disease	0-20
E74.09	Other glycogen storage disease	0-20
E74.12	Hereditary fructose intolerance	0-20
E74.19	Other disorders of fructose metabolism	0-20
E74.21	Galactosemia	0-20
E74.29	Other disorders of galactose metabolism	0-20
E74.4	Disorders of pyruvate metabolism and gluconeogenesis	0-20
E75.00	GM2 gangliosidosis, unspecified	0-20
E75.01	Sandhoff disease	0-20
E75.02	Tay-Sachs disease	0-20

E75.09	Other GM2 gangliosidosis	0-20
E75.10	Unspecified gangliosidosis	0-20
E75.11	Mucolipidosis IV	0-20
E75.19	Other gangliosidosis	0-20
E75.21	Fabry (-Anderson) disease	0-20
E75.22	Gaucher disease	0-20
E75.23	Krabbe disease	0-20
E75.240	Niemann-Pick disease type A	0-20
E75.241	Niemann-Pick disease type B	0-20
E75.242	Niemann-Pick disease type C	0-20
E75.243	Niemann-Pick disease type D	0-20
E75.248	Other Niemann-Pick disease	0-20
E75.25	Metachromatic leukodystrophy	0-20
E75.26	Sulfatase deficiency	0-20
E75.29	Other sphingolipidosis	0-20
E75.3	Sphingolipidosis, unspecified	0-20
E75.4	Neuronal ceroid lipofuscinosis	0-20
E75.5	Other lipid storage disorders	0-20
E76.01	Hurler's syndrome	0-64
E76.02	Hurler-Scheie syndrome	0-64
E76.03	Scheie's syndrome	0-64
E76.1	Mucopolysaccharidosis, type II	0-64
E76.210	Morquio A mucopolysaccharidoses	0-64
E76.211	Morquio B mucopolysaccharidoses	0-64
E76.219	Morquio mucopolysaccharidoses, unspecified	0-64
E76.22	Sanfilippo mucopolysaccharidoses	0-64
E76.29	Other mucopolysaccharidoses	0-64
E76.3	Mucopolysaccharidosis, unspecified	0-64
E76.8	Other disorders of glucosaminoglycan metabolism	0-64
E77.0	Defects in post-translational mod of lysosomal enzymes	0-20
E77.1	Defects in glycoprotein degradation	0-20
E77.8	Other disorders of glycoprotein metabolism	0-20
E79.1	Lesch-Nyhan syndrome	0-64
E79.2	Myoadenylate deaminase deficiency	0-64
E79.8	Other disorders of purine and pyrimidine metabolism	0-64
E79.9	Disorder of purine and pyrimidine metabolism, unspecified	0-64
E80.3	Defects of catalase and peroxidase	0-64
E84.0	Cystic fibrosis with pulmonary manifestations	0-64
E84.11	Meconium ileus in cystic fibrosis	0-64
E84.19	Cystic fibrosis with other intestinal manifestations	0-64
E84.8	Cystic fibrosis with other manifestations	0-64
E84.9	Cystic fibrosis, unspecified	0-64
E88.40	Mitochondrial metabolism disorder, unspecified	0-64
E88.41	MELAS syndrome	0-64
E88.42	MERRF syndrome	0-64
E88.49	Other mitochondrial metabolism disorders	0-64
E88.89	Other specified metabolic disorders	0-64

F84.2	Rett's syndrome	0-20
G11.0	Congenital nonprogressive ataxia	0-20
G11.1	Early-onset cerebellar ataxia	0-20
G11.2	Late-onset cerebellar ataxia	0-20
G11.3	Cerebellar ataxia with defective DNA repair	0-20
G11.4	Hereditary spastic paraplegia	0-20
G11.8	Other hereditary ataxias	0-20
G11.9	Hereditary ataxia, unspecified	0-20
G12.0	Infantile spinal muscular atrophy, type I (Werdnig-Hoffman)	0-20
G12.1	Other inherited spinal muscular atrophy	0-20
G12.21	Amyotrophic lateral sclerosis	0-20
G12.22	Progressive bulbar palsy	0-20
G12.29	Other motor neuron disease	0-20
G12.8	Other spinal muscular atrophies and related syndromes	0-20
G12.9	Spinal muscular atrophy, unspecified	0-20
G24.1	Genetic torsion dystonia	0-64
G24.8	Other dystonia	0-64
G25.3	Myoclonus	0-5
G25.9	Extrapyramidal and movement disorder, unspecified	0-20
G31.81	Alpers disease	0-20
G31.82	Leigh's disease	0-20
G31.9	Degenerative disease of nervous system, unspecified	0-20
G32.81	Cerebellar ataxia in diseases classified elsewhere	0-20
G37.0	Diffuse sclerosis of central nervous system	0-64
G37.5	Concentric sclerosis (Balo) of central nervous system	0-64
G71.00	Muscular dystrophy, unspecified	0-64
G71.01	Duchenne or Becker muscular dystrophy	0-64
G71.02	Facioscapulohumeral muscular dystrophy	0-64
G71.09	Other specified muscular dystrophies	0-64
G71.11	Myotonic muscular dystrophy	0-64
G71.2	Congenital myopathies	0-64
G80.0	Spastic quadriplegic cerebral palsy	0-64
G80.1	Spastic diplegic cerebral palsy	0-20
G80.3	Athetoid cerebral palsy	0-64
G82.50	Quadriplegia, unspecified	0-64
G82.51	Quadriplegia, C1-C4 complete	0-64
G82.52	Quadriplegia, C1-C4 incomplete	0-64
G82.53	Quadriplegia, C5-C7 complete	0-64
G82.54	Quadriplegia, C5-C7 incomplete	0-64
G91.0	Communicating hydrocephalus	0-20
G91.1	Obstructive hydrocephalus	0-20
I67.5	Moyamoya disease	0-64
K91.2	Postsurgical malabsorption, not elsewhere classified	0-20
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions	0-20
N03.2	Chronic nephritic syndrome w diffuse membranous glomrlneph	0-20
N03.3	Chronic neph syndrome w diffuse mesangial prolif glomrlneph	0-20
N03.4	Chronic neph syndrome w diffuse endocaplry prolif glomrlneph	0-20

N03.5	Chronic nephritic syndrome w diffuse mesangiocap glomrlneph	0-20
N03.6	Chronic nephritic syndrome with dense deposit disease	0-20
N03.7	Chronic nephritic syndrome w diffuse crescentic glomrlneph	0-20
N03.8	Chronic nephritic syndrome with other morphologic changes	0-20
N03.9	Chronic nephritic syndrome with unsp morphologic changes	0-20
N08	Glomerular disorders in diseases classified elsewhere	0-20
N18.1	Chronic kidney disease, stage 1	0-20
N18.2	Chronic kidney disease, stage 2 (mild)	0-20
N18.3	Chronic kidney disease, stage 3 (moderate)	0-20
N18.4	Chronic kidney disease, stage 4 (severe)	0-20
N18.5	Chronic kidney disease, stage 5	0-20
N18.6	End stage renal disease	0-20
N18.9	Chronic kidney disease, unspecified	0-20
Q01.9	Encephalocele, unspecified	0-20
Q02	Microcephaly	0-20
Q03.0	Malformations of aqueduct of Sylvius	0-20
Q03.1	Atresia of foramina of Magendie and Luschka	0-20
Q03.8	Other congenital hydrocephalus	0-20
Q03.9	Congenital hydrocephalus, unspecified	0-20
Q04.3	Other reduction deformities of brain	0-20
Q04.5	Megalencephaly	0-20
Q04.6	Congenital cerebral cysts	0-20
Q04.8	Other specified congenital malformations of brain	0-20
Q05.0	Cervical spina bifida with hydrocephalus	0-64
Q05.1	Thoracic spina bifida with hydrocephalus	0-64
Q05.2	Lumbar spina bifida with hydrocephalus	0-64
Q05.3	Sacral spina bifida with hydrocephalus	0-64
Q05.4	Unspecified spina bifida with hydrocephalus	0-64
Q05.5	Cervical spina bifida without hydrocephalus	0-64
Q05.6	Thoracic spina bifida without hydrocephalus	0-64
Q05.7	Lumbar spina bifida without hydrocephalus	0-64
Q05.8	Sacral spina bifida without hydrocephalus	0-64
Q05.9	Spina bifida, unspecified	0-64
Q06.0	Amyelia	0-64
Q06.1	Hypoplasia and dysplasia of spinal cord	0-64
Q06.2	Diastematomyelia	0-64
Q06.3	Other congenital cauda equina malformations	0-64
Q06.4	Hydromyelia	0-64
Q06.8	Other specified congenital malformations of spinal cord	0-64
Q07.01	Arnold-Chiari syndrome with spina bifida	0-64
Q07.02	Arnold-Chiari syndrome with hydrocephalus	0-64
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus	0-64
Q30.1	Agenesis and underdevelopment of nose, cleft or absent nose only	0-5
Q30.2	Fissured, notched and cleft nose, cleft or absent nose only	0-5
Q31.0	Web of larynx	0-20
Q31.8	Other congenital malformations of larynx, atresia or agenesis of larynx only	0-20

Q32.1	Other congenital malformations of trachea, atresia or agenesis of trachea only	0-20
Q32.4	Other congenital malformations of bronchus, atresia or agenesis of bronchus only	0-20
Q33.0	Congenital cystic lung	0-20
Q33.2	Sequestration of lung	0-20
Q33.3	Agenesis of lung	0-20
Q33.6	Congenital hypoplasia and dysplasia of lung	0-20
Q35.1	Cleft hard palate	0-20
Q35.3	Cleft soft palate	0-20
Q35.5	Cleft hard palate with cleft soft palate	0-20
Q35.9	Cleft palate, unspecified	0-20
Q37.0	Cleft hard palate with bilateral cleft lip	0-20
Q37.1	Cleft hard palate with unilateral cleft lip	0-20
Q37.2	Cleft soft palate with bilateral cleft lip	0-20
Q37.3	Cleft soft palate with unilateral cleft lip	0-20
Q37.4	Cleft hard and soft palate with bilateral cleft lip	0-20
Q37.5	Cleft hard and soft palate with unilateral cleft lip	0-20
Q37.8	Unspecified cleft palate with bilateral cleft lip	0-20
Q37.9	Unspecified cleft palate with unilateral cleft lip	0-20
Q39.0	Atresia of esophagus without fistula	0-3
Q39.1	Atresia of esophagus with tracheo-esophageal fistula	0-3
Q39.2	Congenital tracheo-esophageal fistula without atresia	0-3
Q39.3	Congenital stenosis and stricture of esophagus	0-3
Q39.4	Esophageal web	0-3
Q42.0	Congenital absence, atresia and stenosis of rectum with fistula	0-5
Q42.1	Congen absence, atresia and stenosis of rectum without fistula	0-5
Q42.2	Congenital absence, atresia and stenosis of anus with fistula	0-5
Q42.3	Congenital absence, atresia and stenosis of anus without fistula	0-5
Q42.8	Congenital absence, atresia and stenosis of other parts of large intestine	0-5
Q42.9	Congenital absence, atresia and stenosis of large intestine, part unspecified	0-5
Q43.1	Hirschsprung's disease	0-15
Q44.2	Atresia of bile ducts	0-20
Q44.3	Congenital stenosis and stricture of bile ducts	0-20
Q44.6	Cystic disease of liver	0-20
Q45.0	Agenesis, aplasia and hypoplasia of pancreas	0-5
Q45.1	Annular pancreas	0-5
Q45.3	Other congenital malformations of pancreas and pancreatic duct	0-5
Q45.8	Other specified congenital malformations of digestive system	0-10
Q60.1	Renal agenesis, bilateral	0-20
Q60.4	Renal hypoplasia, bilateral	0-20
Q60.6	Potter's syndrome, with bilateral renal agenesis only	0-20
Q61.02	Congenital multiple renal cysts, bilateral only	0-20
Q61.19	Other polycystic kidney, infantile type, bilateral only	0-20
Q61.2	Polycystic kidney, adult type, bilateral only	0-20
Q61.3	Polycystic kidney, unspecified, bilateral only	0-20
Q61.4	Renal dysplasia, bilateral only	0-20
Q61.5	Medullary cystic kidney, bilateral only	0-20

Q61.9	Cystic kidney disease, unspecified, bilateral only	0-20
Q64.10	Exstrophy of urinary bladder, unspecified	0-20
Q64.12	Cloacal extrophy of urinary bladder	0-20
Q64.19	Other exstrophy of urinary bladder	0-20
Q75.0	Craniosynostosis	0-20
Q75.1	Craniofacial dysostosis	0-20
Q75.2	Hypertelorism	0-20
Q75.4	Mandibulofacial dysostosis	0-20
Q75.5	Oculomandibular dysostosis	0-20
Q75.8	Other congenital malformations of skull and face bones	0-20
Q77.4	Achondroplasia	0-1
Q77.6	Chondroectodermal dysplasia	0-1
Q77.8	Other osteochondrodysplasia with defects of growth of tubular bones and spine	0-1
Q78.0	Osteogenesis imperfecta	0-20
Q78.1	Polyostotic fibrous dysplasia	0-1
Q78.2	Osteopetrosis	0-1
Q78.3	Progressive diaphyseal dysplasia	0-1
Q78.4	Enchondromatosis	0-1
Q78.6	Multiple congenital exostoses	0-1
Q78.8	Other specified osteochondrodysplasias	0-1
Q78.9	Osteochondrodysplasia, unspecified	0-1
Q79.0	Congenital diaphragmatic hernia	0-1
Q79.1	Other congenital malformations of diaphragm	0-1
Q79.2	Exomphalos	0-1
Q79.3	Gastroschisis	0-1
Q79.4	Prune belly syndrome	0-1
Q79.59	Other congenital malformations of abdominal wall	0-1
Q89.7	Multiple congenital malformations, not elsewhere classified	0-10
R75	Inconclusive laboratory evidence of HIV	0-12 months
Z21	Asymptomatic human immunodeficiency virus infection status	0-20
Z99.11	Dependence on respirator (ventilator) status	1-64
Z99.2	Dependence on renal dialysis	21-64

ATTACHMENT II

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

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

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

Age: **Chief Complaint:**
HPI:

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

Physical Findings:

General: ☐ Alert/NAD
☐ Pertinent:

Head: ☐ Normal
☐ Pertinent:

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

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

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

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

Neck: ☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: ☐ No lymphadenopathy
☐ Pertinent:

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

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

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

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

Extremities: ☐ FROM
☐ Pertinent:

Neurologic: ☐ Grossly intact
☐ Pertinent:

Skin: ☐ Intact, no rashes
☐ Pertinent:

ASSESSMENT: **PLAN:**

Rx Ordered:

Labs Ordered:

Radiology Services Ordered:

PCP F/U Required:
☐ **Yes** ☐ **No**

Provider Signature: _____

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

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

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

SBHC Name & Address: **SBHC Provider Number:** **Contact Name:** **Telephone:** **Fax:**	**MCO Name & Address:** **Contact Name:** **Telephone:** **Fax:** **Date Faxed:**

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

Age: **Chief Complaint:**
HPI:

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

Physical Findings:

General: ☐ Alert/NAD
☐ Pertinent:

Head: ☐ Normal
☐ Pertinent:

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

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

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

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

Neck: ☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: ☐ No lymphadenopathy
☐ Pertinent:

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

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

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

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

Extremities: ☐ FROM
☐ Pertinent:

Neurologic: ☐ Grossly intact
☐ Pertinent:

Skin: ☐ Intact, no rashes
☐ Pertinent:

ASSESSMENT: **PLAN:**

Rx Ordered:

Labs Ordered:

Radiology Services Ordered:

PCP F/U Required:
☐ **Yes** ☐ **No**

Provider Signature: _____

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ATTACHMENT III

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	http://www.alleganyhealthdept.com/
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	http://www.aahealth.org/
Baltimore City	410-396-4398	410-396-7633	410-640-5000	http://health.baltimorecity.gov/
Baltimore County	410-887-2243	410-887-2828	410-887-8741	http://www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	http://www.calverthealth.org/
Caroline	410-479-8000	410-479-8014	410-479-8189	https://health.maryland.gov/carolinecounty/Pages/NewHome.aspx
Carroll	410-876-2152	410-876-4813	410-876-4941	http://cchd.maryland.gov/
Cecil	410-996-5550	410-996-5171	410-996-5130	http://www.cecilcountyhealth.org
Charles	301-609-6900	301-609-6923	301-609-6760	http://www.charlescountyhealth.org/
Dorchester	410-228-3223	410-901-2426	410-901-8167	http://www.dorchesterhealth.org/
Frederick	301-600-1029	301-600-3124	301-600-3124	http://health.frederickcountymd.gov/
Garrett	301-334-7777	301-334-7727	301-334-7771	http://garretthealth.org/
Harford	410-838-1500	410-638-1671	410-942-7999	http://harfordcountyhealth.com/
Howard	410-313-6300	877-312-6571	410-313-7323	https://www.howardcountymd.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	http://kenthd.org/
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1635	http://www.montgomerycountymd.gov/hhs/
Prince George's	301-883-7879	301-856-9555	301-856-9550	http://www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4456	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-4330	http://www.smchd.org/
Somerset	443-523-1700	443-523-1722	443-523-1758	http://somersethealth.org/
Talbot	410-819-5600	410-819-5609	410-819-5600	https://health.maryland.gov/talbotcounty/Pages/home.aspx
Washington	240-313-3200	240-313-3264	240-313-32229	https://health.maryland.gov/washhealth/Pages/home.aspx
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	https://www.wicomicohealth.org/
Worcester	410-632-1100	410-632-0092	410-629-0614	http://www.worcesterhealth.org/

ATTACHMENT IV **HealthChoice**

LOCAL HEALTH SERVICES REQUEST FORM

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

Client Information

Client Name:
Address:
City/State/Zip:
Phone:
County:
DOB: / / SS#: - -
Sex: ☐M ☐F Hispanic: ☐Y ☐N
MA#:
Private Ins.: ☐ No ☐Yes
Marital Status: ☐Single ☐Married ☐Unknown
If Interpreter is needed specific language:

Race: ☐African-American/Black
☐Alaskan Native ☐American Native
☐Asian ☐Native Hawaiian
☐Pacific Islander ☐White
☐More than one race ☐Unknown

Caregiver/Emergency Contact:

Relationship:
Phone:

FOLLOW-UP FOR: (Check all that apply)
☐Child under 2 years of age
☐Child 2 – 21 years of age
☐Child with special health care needs
☐ Pregnant EDD: ____ / ____ /____
☐Adults with disability(mental, physical, or developmental)
☐Substance use care needed
☐Homeless (at-risk)

RELATED TO: (Check all that apply)
☐Missed appointments: ___ #missed
☐Adherence to plan of care
☐Immunization delay
☐Preventable hospitalization
☐Transportation
☐Other:

Diagnosis:

Comments:

MCO:

Date Received: / /

Document Outreach:
Letter(s) _____ # Phone Call(s) _____
Face to Face _____

☐Unable to Locate
☐Contact Date: / /
☐Advised ☐Refused

Comments:

Contact Person:
Phone:
Fax:

Provider Name:
Provider Phone:

Local Health Department (County)

Date Received: / /

Document Outreach:
Letter(s) _____ # Phone Call(s) _____
Face to Face _____

☐No Action (returned)
Reason for return:

Contact Person:
Contact Phone:

Disposition:
☐Contact Complete: Date: / /
☐Unable to Locate: Date: / /
☐Referred to: Date: / /

Comments:

DHMH 4582 8/14

The latest version of the 2024 Maryland Physicians Care Provider Manual can be found online by visiting our website at **mpc**Medicaid.com.

Please call the Provider Relations Department at 800-953-8854 with any questions or for additional information.

PVR 11.15.24:v3

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