Insert MCO Name
HealthChoice
Provider Manual

Updated May 2022

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 1.2 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://mmcp.health.maryland.gov/healthchoice/Pages/Home.aspx

Providers who wish to serve individuals enrolled in Medicaid MCOs are now required to register with Medicaid. [MCO Insert] 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 his or her patient.

Introduction to MCO [Insert description of organization, service area, etc]

Member Rights and Responsibilities
MCO Insert from Member Manual or attach

HIPAA and Member Privacy Rights

[MCO Insert from Member Manual or attach]

Anti-Gag Provisions

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

(1) Communications that relate to treatment alternatives including medication treatment options regardless of benefit coverage limitations;
(2) Communications that 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 [MCO] that a particular course of medical treatment is not a covered benefit shall not relieve Participating Providers from recommending such care as he/she deems 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 also change their MCO if they have been in the same MCO for 12 or more months. Members may change their MCO and join another MCO near where they live for any of the following reasons at any time:

- If they move to another county where **[MCO insert]** 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 mother was enrolled in on the date of delivery and cannot change for 90 days.

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

[MCO] is required to provide PCPs with their rosters on a monthly basis**. [MCO to insert details on method and disclaimers such as information changes daily and should not be used to determine member eligibility.]** MCO members may change PCPs at any time. Members can call [MCO] Member Services Monday-Friday [insert time] at [insert number] to change their PCP.

GG[Optional if consistent with MCO policy or delete] PCPs may see [MCO] 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 [MCO], the PCP may see the [MCO] member. However, [MCO] 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 [MCO]
[MCO insert]

Provider Reimbursement

Payment to providers is in accordance with your provider contract with **[MCO Name]** or with their management groups that contract on your behalf with **[MCO Name]**. 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. **[MCO Name]** 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. **[MCO name]** 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 [insert#] 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 **[MCO Name]** network under certain conditions. See Section II for additional information.

If a provider contracts with **[MCO Name]** for any of the services listed above the provider must follow our billing and preauthorization procedures. Reimbursements will be paid at 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 **[MCO Name]** from another MCO.

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

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

Preauthorization for health care services

If the previous MCO or company preauthorized services we will honor the approval if the member calls **[MCO insert number]**. 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 **[MCO Name]** Member Services at **[MCO insert number]** 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
[MCO Insert description of Services]

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). [MCO Name] will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD. **See Attachment [Insert#] for NEMT contact information.**

MCO Transportation Assistance
Under certain circumstances [MCO Name] may provide limited transportation assistance when members do not qualify for NEMT through the LHD. [MCO Name Description of MCO Transportation]

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 [Insert #] 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 postpartum women who have not started to receive care, the initial health visit must be scheduled and the women 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 **[MCO name]'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

[MCO Name] will assign children and adolescents under age 21 to a PCP who is certified by the EPSDT/Healthy Kids Program. If a 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 child care 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 [Insert#]. 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, caregivers 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 **[MCO Name]**at **[MCO insert number].** You may concurrently make a written referral to the LHD ACCU by completing the Local Health Services Request form. **See Attachment [Insert #].** Continue to work collaboratively with **[MCO Name]** 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 **[MCO Name]** 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 women
- 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 will 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 **[MCO insert number]**.
- 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 **[MCO Name]**. If a member continues to miss appointments, call **[MCO Name]** at **[MCO insert number]**. 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 [Insert#] or** https://mmcp.health.maryland.gov/pages/Local-Health-Services-Request-Form.aspx). The local ACCU staff will work collaboratively with **[MCO Name]** 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 Women

Prenatal care providers are key to assuring that pregnant women have access to all available services. Many pregnant women will be new to HealthChoice and will only be enrolled in Medicaid during pregnancy and the postpartum period. Medicaid provides full benefits to these women 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://mmcp.health.maryland.gov/Documents/Factsheet3_Maryland%20Family%20Planning%20Waiver%20Program.pdf)

[MCO Name] 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 4950). **See Attachment [Insert#];**
- 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 women 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 women;
- 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 women:

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

Encourage all pregnant women to call the State's Helpline for Pregnant Woman at 1-800-456-8900. This is especially important for women who are newly eligible or not yet enrolled in Medicaid. If the woman is already enrolled in HealthChoice call us and also instruct her to call our [MCO Name unit and number].

Pregnant women 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 **[MCO Name]**. 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 **[MCO Name]** 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 [Insert#]** during the initial visit and submit it to the Local Health Department within 10 days of the initial visit. **[MCO Name]** 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. **[MCO Name]** 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 women 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 **[MCO Name]** if a prenatal appointment is not kept within 30 days of the first missed appointment.

- Refer pregnant women 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 women 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.
- Refer eligible pregnant women to receive doula services or 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 she 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 mother'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 she requests that her newborn remain in the hospital while she is 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 mother 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 mother;
- 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 mothers. Call us at **[MCO Name number].**

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 **[MCO Name]**. 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 **[MCO Name]** and we approve the services as medically necessary.

Established Member: A child who is already enrolled in **[MCO Name]** 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 **[MCO Name]** 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 **[MCO Name]** 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 **[MCO Name]** 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.

[MCO Name] 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 [MCO Name] or they may receive services through the traditional Medicaid fee-for-service program. They cannot be in both an MCO and REM. **See Attachment [Insert#]** 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

[MCO Name] 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 **[MCO Name]** 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 **[MCO Name]** case management program.

[MCO insert additional case management details/description]

Clinical Trial Items and Services

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

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:

[MCO Insert disease management details/description]

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 **[MCO insert]**, 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 on the basis of 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; members must be 21 years of age and must use in-network providers or have authorization for out of network care.)

Gender Transition Services

We cover medically necessary gender reassignment surgery and other somatic care for members with gender identity disorder.

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 **[MCO insert number].**

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 his/her 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 with, must pay the out-of-network hospice provider.

Inpatient Hospital Services
We cover inpatient hospital services. **[MCO Name]** 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.

Nursing Facility Services
For members that were enrolled in **[MCO Name]** prior to admission to a nursing facility, chronic hospital or chronic rehabilitation hospital and who meet the State's level of care (LOC) criteria, [MCO] 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 **[MCO Name]** 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 women, 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. **[Insert description of MCO pharmacy copays]**

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
Refer to Section **[MCO Insert Section #]**
[MCO to Insert any additional information]

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. **[MCO to add details and any optional services]**

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

Vision Care Services
We cover medically necessary vision care services. We are required to cover one eye examination every two years for members age 21 or older; and for members under age 21, at least one eye examination every year in addition to EPSDT screening. For members under age 21 we are required to cover one pair of eyeglasses per year unless lost, stolen, broken, or no longer vision appropriate; contact lenses must be covered if eyeglasses are not medically appropriate for the condition. **[MCO Name]** covers additional vision services for adults. We will cover: **[MCO Name adult vision benefit including limitations if applicable]**

OPTIONAL SERVICES COVERED BY [MCO Name]
In addition to those services previously noted **[MCO Name]** 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 the State.

MEDICAID BENEFITS COVERED BY THE STATE - not covered by [MCO Name]

- **The State covers dental** services for children under age 21, former foster care youth up to age 26, and pregnant women. 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 Scion the States ASO. Scion 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 for children and pregnant women 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 woman was determined eligible for Medicaid based on her pregnancy she is 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
- The Spinal Muscular Atrophy drug Zolgensma.

BENEFIT LIMITATIONS
[MCO Name] 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 **[MCO Name]** 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;
- Dental services for adult members (age 21 and older - except pregnant women and former foster care youth up to age 26);
- 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;
- Reversal of gender reassignment surgeries;
- Medications for the treatment of sexual dysfunction;
- MCOs are not permitted to cover abortions. We are required to assist women 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; **[MCO Name if offered.]**
- Lifestyle improvements (physical fitness programs and nutrition counseling, unless specified); and **[MCO Name if offered.]**
- MCOs do not cover emergency transportation services and are not required to cover non-emergency transportation services (NEMT). **[MCO Name]** 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. **[MCO insert transportation services provided]**

Section IV

PRIOR AUTHORIZATION
AND
MEMBER COMPLAINT, GRIEVANCE
AND APPEAL PROCEDURES

Services requiring prior authorization
[MCO insert]

Services not Requiring Preauthorization

Prior authorizations procedures
[MCO insert]

Inpatient Admissions and Concurrent Review

Period of preauthorization
Prior authorization numbers are valid for the date of service authorized or for a period not to exceed **[INSERT**] days after the date of service authorized. The member must be eligible for Medicaid and enrolled in [MCO] on each date of service. For information about how to verify member eligibility **[MCO Insert].**

Prior authorization and coordination of benefits
[MCO Name] 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
[MCO Insert] (additional criteria if applicable)

Timeliness of decisions and notifications to providers and members
[MCO Name] makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the Maryland Department of Health. **[MCO Name]** 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.

[MCO Name] 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, [MCO] will assign a prior authorization number, which refers to and documents the approval. [MCO] 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 a 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. [MCO] makes such decisions on a case-by-case basis.

Overview of Member Complaint, Grievance and Appeal Processes

Our MCO member services line, **[MCO insert number], operates [MCO insert hours].** Member services resolves or properly refers members' inquiries or complaints to the State or other agencies. **[MCO Name**] 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 **[MCO Name]** website at **[MCO Insert].**

Members or their authorized representatives can file an appeal or a grievance with **[MCO Name]** 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 [**MCO Name**], free of charge, to help with their appeal by calling [MCO phone number]:
- Medical records;
- Any benefit provision, guideline, protocol, or criterion **[MCO Name]** used to make its decision;
- Oral interpretation and written translation assistance; and
- Assistance with filling out [MCO]'s appeal forms.

[MCO Name] 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 **[MCO Name]** or the Department.

[MCO Name] 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 **[MCO Name]**.

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. **[MCO Name]** 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 his/her health care needs.
- The member is dissatisfied with the help he/she received from the provider's staff or **[MCO Name]**.

Examples of reasons to file a medical grievance include:

- The member is having issues with filling his/her prescriptions or contacting the provider.
- The member does not feel he/she is receiving the right care for his/her condition.
- **[MCO Name]** is taking too long to resolve the member's appeal or grievance about a medical issue.
- **[MCO Name]** denies the member's request to expedite his/her appeal about a medical issue.

Grievances may be filed at any time with **[MCO Name]** orally or in writing by the member or their authorized representative, including providers. **[MCO Name]** 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, **[MCO Name]** 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:

- **[MCO Name]** 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.
- **[MCO Name]** 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 he/she has reached the frequency of physical therapy visits allowed.
    - The member has been prescribed a medication, it runs out, and he/she does not receive any more refills for the medication.
- **[MCO Name]** denies all or part of payment for a service a member has received, and the denial was not related to the claim being "clean."
- **[MCO Name]** 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 his/her provider requested).
- **[MCO Name]** 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:

- **[MCO Name]'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 **[MCO Name]'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 **[MCO Name],** 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 **[MCO Name]** make a decision, they may call **[MCO Name]** at 1-000-000-0000 and ask for an extension.

[MCO Name] 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 his/her 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. **[MCO Name]** 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 **[MCO Name]** 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. **[MCO Name]** 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. **[MCO Name]** 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, **[MCO Name]** will communicate the decision verbally at the time of the decision and in writing, including an explanation for the decision, within 24 hours of the decision.

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

Request to Continue Benefits During the Appeal

If the member's appeal is about ending, stopping, or reducing a service that was authorized, they may be able to continue to receive the service while we review their appeal. Providers may not request to continue benefits on the member's behalf. The member should contact us within 10 days of receiving the denial notice at **[MCO insert number]** 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 **[MCO Name]** 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 **[MCO Name]** 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 **[MCO Name**]. If **[MCO Name]** 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, **[MCO Name]** 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 **[MCO Name]** 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

[MCO Name] 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, a 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.

[MCO Name] contracts with **[Insert PBM]** to provide the following services: pharmacy network contracting and network Point-of-Sale (POS) claim processing.

Mail Order Prescriptions

We cannot require a member to use mail-order but we do offer mail-order pharmacy services for certain drugs (delete if not applicable)

[MCO Insert, description of mail order program if applicable]

Specialty Pharmacy Services

For specialty pharmacy services **[MCO Name]** contracts with **[MCO insert details]**

[MCO Name] is responsible for formulary development, drug utilization review, and prior authorization. **[MCO Name]'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 **[MCO Name]** formulary, [insert where to view formulary], before writing a prescription for either prescription or over-the-counter drugs **[MCO Name]** 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 women, individuals in a nursing facility or hospice, or for family planning. [MCO Insert copay information]

Over- the-Counter Products

[MCO insert details]

Injectables and Non-Formulary Medications Requiring Prior-Authorization

Prior Authorization Process

[MCO insert details]

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

Step Therapy and Quantity Limits

[MCO Insert]

Maryland Prescription Drug Monitoring Program

[MCO Name] 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 **[MCO insert number]** if a member is having difficulty filling a prescription. The CMC program is particularly concerned with appropriate utilization of opioids and benzodiazepines. [MCO insert] 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.

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

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

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

Guidance:

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

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

[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

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) on July 1, 2018.

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

You must verify through the Eligibility Verification System (EVS) that participants are assigned to **[MCO Name]** before rendering services. **[MCO insert detail]**

- 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 [MCO Name]

[MCO Insert]

Billing inquiries

[MCO Insert]

Provider Appeal of [MCO Name] Claim Denial

[MCO insert]

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 **[MCO]** but MDH cannot compel **[MCO]** to pay claims that **[MCO]** 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.MDH.maryland.gov/SitePages/IRO%20Information.aspx.The IRO

does not accept cases for review which involve disputes between the Behavioral Health ASO and **[MCO]**

MCO Quality Initiatives

[MCO Insert description]

Provider Performance Data]

[MCO Insert description]

Pay for Performance

[MCO Insert description] (if applicable)

Section VII.

PROVIDER SERVICES AND RESPONSIBILITIES

Overview of [MCO] Provider Services
[MCO- Insert description and contact information]

Provider Web Portal
[MCO Insert]

Provider Inquiries
[MCO Insert]

Re-Credentialing
[MCO Insert]

Overview of Provider Responsibilities
[MCO Insert]

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, Nurse Practitioner or Physician's Assistant as their PCP. The PCP will act as a coordinator of care and has the responsibility to provide accessible, comprehensive, and coordinated health care services covering the full range of benefits.

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

If a woman's PCP is not a women's health specialist, **[MCO Name]** will allow her to see a women's health specialist within **the MCO 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
- **[Insert MCO]** reduces your reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to **[Insert MCO]** by the Department, and **[Insert MCO]** 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 **[MCO]** 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 **[MCO Name number]** for assistance.

[MCO Insert additional information]

Out of Network Providers and Single Case Agreements

[MCO Insert additional information]

Second Opinions

If a member requests a second opinion, [MCO] 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:

[MCO insert address]

- 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.

[MCO Insert additional information]

Medical Records Requirements

[MCO insert additional information]

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 **[MCO Name]** 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 his or her 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).

Advance directive forms and frequently asked questions can be found at:
www.marylandattorneygeneral.gov/Pages/HealthPolicy/advancedirectives.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 the 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. **[MCO insert]** 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

[MCO Name]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.
[MCO insert additional information on Interpreter Services]

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.

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. On a daily basis and through a systematic audit of MCO operations and health care delivery, the Department identifies both positive and negative trends in service delivery. Quality monitoring and evaluation and education through member and provider feedback are an integral part of the managed care process and help to ensure that cost containment activities do not adversely affect the quality of care provided to members.

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

- Health Service Needs Information form completed by the participant at the time they select an MCO to assure that the MCO is alerted to immediate health needs, e.g., prenatal care service needs;
- A complaint process administered by MDH staff;
- A complaint process administered by **[MCO Name]**;
- 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.

In order to report these measures to MDH, **[MCO insert]** must perform chart audits throughout the year to collect clinical information on our Members. **[MCO insert]** truly appreciates the provider offices' cooperation when medical records are requested.

In addition to information reported to MDH, **[MCO Name]** 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

[MCO insert description of fraud detection program]

Reporting Suspected Fraud and Abuse

Participating providers are required to report to **[MCO Name]** all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

[MCO insert process for reporting to MCO].

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 [MCO Name]**services through Maryland HealthChoice.

Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68), **[MCO Name]**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 **[MCO Name]**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
[MCO Name] 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.

[MCO Name] 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 **[MCO Name]**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

ATTACHMENT X

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 **[MCO Name]** 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 are 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/caregivers, 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 he/she 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 will 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 X

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

ATTACHMENT X

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	410-396-3835	410-396-6422	410-649-0521	http://health.baltimorecity.gov/
Baltimore County	410-887-2243	410-887-2828	410-887-4381	http://www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	http://www.calverthealth.org/
Caroline	410-479-8000	410-479-8014	410-479-8023	https://health.maryland.gov/carolinecounty/Pages/NewHome.aspx
Carroll	410-876-2152	410-876-4813	410-876-4940	http://cchd.maryland.gov/
Cecil	410-996-5550	410-996-5171	410-996-5145	http://www.cecilcountyhealth.org
Charles	301-609-6900	301-609-7917	301-609-6803	http://www.charlescountyhealth.org/
Dorchester	410-228-3223	410-901-2426	410-228-3223	http://www.dorchesterhealth.org/
Frederick	301-600-1029	301-600-1725	301-600-3341	http://health.frederickcountymd.gov/
Garrett	301-334-7777	301-334-9431	301-334-7695	http://garretthealth.org/
Harford	410-838-1500	410-638-1671	410-942-7999	http://harfordcountyhealth.com/
Howard	410-313-6300	877-312-6571	410-313-7567	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	240-777-1648	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	443-262-4481	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-6772	http://www.smchd.org/
Somerset	443-523-1700	443-523-1722	443-523-1766	http://somersethealth.org/
Talbot	410-819-5600	410-819-5609	410-819-5654	https://health.maryland.gov/talbotcounty/Pages/home.aspx
Washington	240-313-3200	240-313-3264	240-313-3290	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	410-632-9230	http://www.worcesterhealth.org/

ATTACHMENT X

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

HealthChoice
LOCAL HEALTH SERVICES REQUEST FORM

Client Information

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

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

DHMH 4582 8/14

ATTACHMENT X

MARYLAND PRENATAL RISK ASSESSMENT

REFER TO INSTRUCTIONS ON BACK BEFORE STARTING

Date of Visit: _____/_____/_____

Provider Name:_____ Provider Phone Number: _____- _____- _____

Provider NPI#: __ __ __ __ __ Site NPI#: __ __ __ __ __

Client Last Name: _____ First Name: _____ Middle:_____

House Number: _____ Street Name: _____ Apt: _____ City:

County (If patient lives in Baltimore City, leave blank): _____ State: _____ Zip Code:

Home Phone #: _____-_____-_____ Cell Phone#: _____-_____-_____ Emergency Phone#: _____- _____-_____

SSN: _____ - _____ - _____ DOB: _____ / ____ / _____ Emergency Contact:_____
Name/Relationship

Race:
___ African-American or Black
___ Alaskan Native ___ American Native
___ Asian ____More than 1 race
___ Native Hawaiian or other Pacific Islander
___ Unknown ___ White

Language Barrier? ___ Yes ___ No
Specify Primary Language _____
Hispanic? ___ Yes ___ No

Marital Status:
___ Married ___ Unmarried ___ Unknown

Payment Status (Mark all that apply):
_____ Private Insurance, Specify:
_____ MA/HealthChoice
MA #:_____
Name of MCO (if applicable): _____
_____ Applied for MA Specify Date: ____ /____ /
____ Uninsured
_____ Unknown

Educational Level
Highest grade completed: _____ GED? ___ Yes ___ No
Currently in school? ___ Yes ___ No

Transferred from other source of prenatal care ? ___ Yes ___ No
If YES, date care began: _____/_____/ _____

Other source of prenatal care: _____

Trimester of 1st prenatal visit: _____1st _____2nd _____3rd

LMP: _____/_____/_____ Initial EDC: _____/_____/_____

Complete all that apply
_____# Full-term live births
_____# Preterm live births
_____# Prior LBW births
_____# Spontaneous abortions
_____# Therapeutic abortions
_____# Ectopic pregnancies
_____# Children now living

Check all that apply
____History of preterm labor
____History of fetal death (> 20 weeks)
____History of infant death w/in 1 yr of age
____History of multiple gestation
____History of infertility treatment
____First pregnancy

Psychosocial Risks: Check all that apply.

_____Current pregnancy unintended
_____Less than 1 year since last delivery
_____Late registration (more than 20 weeks gestation)
_____Disability (mental/physical/developmental), Specify _____
_____History of abuse/violence within past 6 months
_____Tobacco use, Amount _____
_____Alcohol use, Amount _____
_____Illegal substances within past 6 months
_____Resides in home built prior to 1978, _____Rent _____Own
_____Homelessness
_____Lack of social/emotional support
_____Exposure to long-term stress
_____Lack of transportation
_____Other psychosocial risk (specify in comments box)
_____None of the above

COMMENTS ON PSYCHOSOCIAL RISKS:

Medical Risks: Check all that apply.
Current Medical Conditions of this Pregnancy:

_____Age ≤15
_____Age ≥ 45
_____BMI < 18.5 or BMI > 30
_____Hypertension (> 140/90)
_____Anemia (Hgb < 10 or Hct < 30
_____Asthma
_____Sickle-cell disease
_____Diabetes: Insulin dependent _____Yes _____No
_____Vaginal bleeding (after 12 weeks)
_____Genetic risk: specify _____
_____Sexually transmitted disease, Specify _____
_____Last dental visit over 1 year ago
_____Prescription drugs
_____History of depression/mental illness, Specify_____
Depression assessment completed? _____Yes _____No
_____Other medical risk (specify in comment box)
_____None of the above

COMMENTS ON MEDICAL RISKS:

Form Completed By:_____
Date Form Completed: _____/_____/_____

MDH 4850 revised March 2014

DO NOT WRITE IN THIS SPACE 9005

Maryland Prenatal Risk Assessment Form Instructions

Purpose of Form: **Identifies pregnant women who may benefit from local health department Administrative Care Coordination (ACCU) services and serves as the referral mechanism. ACCU services complement medical care and may be provided by public health nurses and social workers through the local health departments. Services may include resource linkage, psychosocial/environmental assessment, reinforcement of the medical plan of care, and other related services.**

Form Instructions: On the initial visit the provider/staff will complete the demographic and assessment sections for ALL pregnant women enrolled in Medicaid at registration and those applying for Medicaid. Within ten (10) days of completing the prenatal risk assessment, forward this instrument to the local health department in the jurisdiction in which the pregnant enrollee lives.

NEW - Enter both the provider and site/facility NPI numbers.

Print clearly; use black pen for all sections.

Press firmly to imprint.

White-out previous entries on original completely to make corrections.

If client does not have a social security number, indicate zeroes.

Indicate the person completing the form.

Review for completeness and accuracy.

Faxing and Handling Instructions:

Do not fold, bend, or staple forms. ONLY PUNCH HOLES AT TOP OF FORM IF NECESSARY.Store forms in a dry area. **Fax the MPRAF to the local health department in the client's county of residence.** To reorder forms call the local **ACCU**.

Definitions (selected): Data may come from self-report, medical records, provider observation or other sources.

DEFINITIONS	
Alcohol use	Is a "risk-drinker" as determined by a screening tool such as MAST, CAGE, TACE OR 4Ps
Current history of abuse/violence	Includes physical, psychological abuse or violence within the client's environment within the past six months
Exposure to long-term stress	For example: partner-related, financial, safety, emotional
Genetic risk	At risk for a genetic or hereditary condition
Illegal substances	Used illegal substances within the past 6 months (e.g. cocaine, heroin, marijuana, PCP) or is taking methadone/buprenorphine
Lack of social/emotional support	Absence of support from family/friends. Isolated
Language barrier	In need of interpreter, e.g. Non-English speaking, auditory processing disability, deaf
Oral Hygiene	Presence of dental caries, gingivitis, tooth loss
Preterm live birth	History of preterm birth (prior to the 37th gestational week)
Prior LBW birth	Low birth weight birth (under 2,500 grams)
Sickle cell disease	Documented by medical records
Tobacco use	Used any type of tobacco products within the past 6 months

Client's Local Health Department Addresses (rev 03/2014) (FAX to the ACCU in the jurisdiction where the client reside.

Mailing Address	Phone Number
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-5094 Fax: 301-777-2401
Anne Arundel County ACCU 1 Harry S. Truman Parkway, Ste 200 Annapolis, MD 21401	410-222-7541 Fax: 410-222-4150
Baltimore City ACCU HealthChare Access Maryland 201 E. Baltimore St, Ste. 1000 Baltimore, MD 21202	410-649-0526 Fax: 1-888-657-8712
Baltimore County ACCU 6401 York Rd., 3rd Floor Baltimore, MD 21212	410-887- 4381 Fax: 410-828-8346
Calvert County ACCU 975 N. Solomon's Island Rd, P.O. Box 980 Prince Frederick, MD 20678	410-535-5400 Fax: 410-535-1955
Caroline County ACCU 403 S. 7th St., P.O. Box 10 Denton, MD 21629	410-479-8023 Fax: 410-479-4871
Carroll County ACCU 290 S. Center St, P. O. Box 845 Westminster, MD 21158-0845	410-876-4940 Fax: 410-876-4959
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5145 Fax: 410-996-0072
Charles County ACCU 4545 Crain Highway, P.O. Box 1050 White Plains, MD 20695	301-609-6803 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-228-3223 Fax: 410-228-8976
Frederick County ACCU 350 Montevue Lane Frederick, MD 21702	301-600-3341 Fax: 301-600-3302
Garrett County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7692 Fax: 301-334-7771
Harford County ACCU 34 N. Philadelphia Blvd. Aberdeen, MD 21001	410-273-5626 Fax: 410-272-5467
Howard County ACCU 7180 Columbia Gateway Dr. Columbia, MD 21044	410-313-7323 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7039 Fax: 410-778-7019
Montgomery County ACCU 1335 Piccard Drive, 2nd Floor Rockville, MD 20850	240-777-1635 Fax: 240-777-4645
Prince George's County ACCU 9201 Basil Court, Room 403 Largo, MD 20774	301-883-7231 Fax: 301-856-9607
Queen Anne's County ACCU 206 N. Commerce Street Centreville, MD 21617	443-262-4481 Fax: 443-262-9357
St Mary's County ACCU 21580 Peabody St., P.O. Box 316 Leonardtown, MD 20650-0316	301-475-4951 Fax: 301-475-4350
Somerset County ACCU 7920 Crisfield Highway Westover, MD 21871	443-523-1740 Fax: 410-651-2572
Talbot County ACCU 100 S. Hanson Street Easton, MD 21601	410-819-5600 Fax: 410-819-5683
Washington County ACCU 1302 Pennsylvania Avenue Hagerstown, MD 21742	240-313-3229 Fax: 240-313-3222

Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6568
Worcester County ACCU 9730 Healthway Dr. Berlin, MD 21811	410-629-0164 Fax: 410-629-0185