



CareFirst BlueCross BlueShield Community Health Plan Maryland

Provider Manual

Contents

I. The Maryland HealthChoice Program5

Medicaid and HealthChoice	5
Introduction to CareFirst BlueCross BlueShield Community Health Plan Maryland.....	5
Member Rights and Responsibilities	6
HIPAA and Member Privacy Rights	7
Anti-Gag Provisions	7
Assignment and Reassignment of Members.....	8
Credentialing and Contracting with CareFirst CHPMD	8
Provider Reimbursement.....	9
Self-Referral and Emergency Services	9
Maryland Continuity of Care Provisions.....	10

II. Outreach and Support Services, Appointment Scheduling, EPSDT, and Special Populations 11

MCO Member Outreach and Support Services.....	11
State Non-Emergency Medical Transportation (NEMT) Assistance	11
MCO Transportation Assistance.....	11
State Support Services.....	11
Scheduling Initial Appointments	11
Early Periodic Screening Diagnostic and Treatment (EPSDT) Requirements	12
EPSDT Outreach and Referral to LHD.....	13
Special Populations	13
Special Needs Population-Outreach and Referral to the LHD	14
Services for Pregnant and Postpartum Members...	14
Childbirth Related Provisions	16
Children with Special Healthcare Needs.....	17
Children in State-Supervised Care	17
Individuals with HIV/AIDS.....	17
Individuals with Physical or Developmental Disabilities	18

Homeless Individuals.....	18
Rare and Expensive Case Management Program	18

III. HealthChoice Benefits and Services..... 19

MCO Benefits and Services Overview.....	19
Audiology Services.....	19
Blood and Blood Products	19
Case Management Services	19
Clinical Trial Items and Services	19
Dental Services.....	19
Diabetes Care Services	19
Diabetes Prevention Program	20
Diagnostic and Laboratory Services.....	20
Dialysis Services	20
Disease Management	20
Durable Medical Services and Durable Medical Equipment	20
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services	20
Family Planning Services	21
Gender-Affirming Services	21
Habilitation Services.....	21
Home Health Services.....	21
Hospice Care Services.....	21
Inpatient Hospital Services.....	21
Mobile Integrated Community Health.....	22
Nursing Facility Services	22
Outpatient Hospital Services	22
Outpatient Rehabilitative Services	22
Oxygen and Related Respiratory Equipment	22
Pharmacy Services and Copays.....	22
Plastic and Restorative Surgery.....	22
Podiatry Services	22
Pregnancy-Related Care	22
Primary Behavioral Health Services.....	22
Specialty Care Services	23
Telemedicine and Remote Patient Monitoring ..	23
Transplants.....	23
Vision Care Services	23
Optional Services Covered By CareFirst CHPMD ..	23

Medicaid Benefits Covered By The State— Not Covered by CareFirst CHPMD.....	23
Benefit Limitations	24

IV. Prior Authorization and Member Complaint, Grievance, and Appeal Procedures.....26

Services Requiring Prior Authorization	26
Services Not Requiring Prior Authorization.....	27
Prior Authorization Procedures.....	28
Inpatient Admissions and Concurrent Review	28
Period of Prior Authorization.....	29
Prior Authorization and Coordination of Benefits ..	29
Medical Necessity Criteria.....	29
Clinical Guidelines	29
Timeliness of Decisions and Notifications to Providers and Members	29
Out-of-Network Providers.....	30
Overview of Member Complaint, Grievance, and Appeal Processes.....	30
MCO Member Grievance Procedures.....	30
MCO Member Appeal Procedures	31
Request to Continue Benefits During the Appeal ...	33
State Fair Hearing Rights	33
State HealthChoice Help Lines	33

V. Pharmacy Management.....34

Pharmacy Benefit Management.....	34
Mail Order Prescriptions	34
Specialty Pharmacy Services.....	34
Prescription and Drug Formulary	35
Prescription Copays	35
Over-the-Counter Products.....	35
Injectables and Non-Formulary Medications Requiring Prior-Authorization.....	35
Prior Authorization Process	35
Step Therapy and Quantity Limits	35
Maryland Prescription Drug Monitoring Program ..	35

VI. Claims Submission, Provider Appeals, Quality Initiatives, Provider Performance Data, and Pay for Performance.....38

Facts to Know Before You Bill.....	38
Submitting Claims to CareFirst CHPMD	38
Billing Inquiries	39
Provider Appeal of CareFirst CHPMD Claim Denial	39
Notification of the Outcome of Appeal	39
State’s Independent Review Organization (IRO) ...	40
MCO Quality Initiatives	40
Provider Performance Data	41
Pay for Performance	41

VII. Provider Services and Responsibilities 42

Overview of CareFirst CHPMD Provider Services and Responsibilities	42
Provider Website	42
Learning and Engagement Center	42
Training Options Available	42
Re-Credentialing	42
Ongoing Monitoring of Sanctions	43
Adding a New Practitioner to Your Existing Group Practice	43
Provider Data Accuracy	43
Primary Care Providers (PCPs).....	43
PCP Contract Terminations.....	44
Specialty Providers.....	44
Out-of-Network Providers and Single Case Agreements.....	44
Second Opinions.....	44
Provider Requested Member Transfer.....	44
Medical Records Requirements.....	44
Confidentiality and Accuracy of Member Records..	45
Reporting Communicable Disease.....	45
Advance Directives	45
Health Insurance Portability and Accountability Act of 1997 (HIPAA)	46

Cultural Competency	46
Health Literacy—Limited English Proficiency (LEP) or Reading Skills	46
Access for Individuals with Disabilities.....	46

VIII. Quality Assurance Monitoring Plan and Reporting Fraud, Waste, and Abuse....47

Quality Assurance Monitoring Plan	47
Fraud, Waste, and Abuse Activities.....	48
Reporting Suspected Fraud and Abuse.....	48
Relevant Laws	49
Exclusion Lists & Death Master Report	50
Additional Resources	50

Attachment A: Rare and Expensive Case Management (REM) Program51

Medicaid Benefits and REM Case Management ...	51
Referral and Enrollment Process	51
Table of Rare and Expensive Diagnosis.....	52

Attachment B	60
---------------------------	-----------

Attachment C	61
---------------------------	-----------

Attachment D	62
---------------------------	-----------

Attachment E.....	63
--------------------------	-----------

Attachment F.....	66
--------------------------	-----------

Attachment G	67
---------------------------	-----------

Case Management Services	67
--------------------------------	----

Attachment H.....	68
--------------------------	-----------

Disease Management	68
--------------------------	----

Attachment I	69
---------------------------	-----------

Telemedicine, and Remote Patient Monitoring	69
--	----

Attachment J	70
---------------------------	-----------

Additional Services Offered By MCO	70
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I. The Maryland HealthChoice Program

Medicaid and HealthChoice

HealthChoice is the name of Maryland Medicaid's managed care program. There are approximately 1.7 million Marylanders enrolled in Medicaid and the Maryland Children's Health Program. With few exceptions, Medicaid beneficiaries under age 65 must enroll in HealthChoice. Individuals that do not select a Managed Care Organization (MCO) will be auto-assigned to an MCO with available capacity that accepts new enrollees in the county where the beneficiary lives. Individuals may apply for Medicaid, renew their eligibility and select their MCO online at marylandhealthconnection.gov or by calling 855-642-8572; TTY: 855-642-8573.

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 healthcare. 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: health.maryland.gov/mmcp/HealthChoice/Pages/Home.aspx.

Providers who wish to serve individuals enrolled in Medicaid MCOs are now required to register with Medicaid. CareFirst BlueCross BlueShield Community Health Plan Maryland (CareFirst CHPMD) 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 temporary 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: eprep.health.maryland.gov. All providers must verify Medicaid and MCO eligibility through the Eligibility Verification System (EVS) before rendering services.

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

Introduction to CareFirst BlueCross BlueShield Community Health Plan Maryland

Welcome to the CareFirst CHPMD network. As a valued Participating Provider, you provide services to members of **CareFirst BlueCross BlueShield Community Health Plan Maryland (CareFirst CHPMD)**.

CareFirst CHPMD works with our network of physicians and healthcare providers to deliver the best quality care to our members. We believe the doctor-patient relationship is critical to good patient care. We believe that all healthcare is delivered locally and supporting our provider network is critical to our success.

Our Medicaid service area includes Baltimore City and all counties in Maryland: Allegheny, Anne Arundel, Baltimore, Baltimore City, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, Somerset, St. Mary's, Talbot, Washington, Wicomico, and Worcester.

For provider contracting information, please visit carefirst.com/medicaid/provider/become-in-network-provider.html.

I. The Maryland HealthChoice Program

Member Rights and Responsibilities

Members have the right to:

- Be treated with respect to your dignity and privacy by healthcare providers, their staff and all individuals employed by CareFirst CHPMD.
- Receive information, including information on treatment options and alternatives regardless of cost or benefit coverage, in a manner you can understand.
- Take part in decisions about your healthcare, including the right to refuse treatment. If you are under 18 and married, pregnant, or have a child, you can expect that you will be able to participate in and make decisions about your and/or your child's healthcare.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Talk to your Primary Care Provider (PCP) about your medical record, request, and get a copy of your medical record, or ask that these records be amended or changed as allowed.
- Have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Exercise your rights and to know that the use of those rights will not badly affect the way that CareFirst CHPMD or our providers treat you.
- File appeals and grievances with us about our organization or the care we provide, including requesting an independent review of a decision to deny or limit coverage (see the section on Grievances and Appeals).
- File appeals and grievances with the State (see **page 30**, the section on the State's Complaint Process).
- Receive a State fair hearing (see the section on the State's Appeal Process). Request that ongoing benefits be continued during an appeal or state fair hearing however, you may have to pay for the continued benefits if our decision is upheld in the appeal or hearing.
- Know you or your provider cannot be penalized for filing a grievance or appeal.

- Get a second opinion from a CareFirst CHPMD provider or arrange for a second opinion from a doctor outside the network if you do not agree with your doctor's opinion about the services that you need. Call us at 410-779-9369 or 800-730-8530 for help with this. TTY users should call 711.
- Have information about how CareFirst CHPMD is managed, including our services, policies and procedures, providers and member rights, and responsibilities and any changes made. Call us at 410-779-9369 or 800-730-8530 for help with this. TTY users should call 711.
- Make recommendations regarding our member rights and responsibilities.
- Expect that your records and communications will be treated confidentially and not released without your permission.
- Choose your own PCP, choose a new PCP, and have privacy during a visit with your PCP.
- Get help from someone who speaks your language.

Members have the responsibility to:

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

I. The Maryland HealthChoice Program

- Provide the MCO and their providers with accurate health information in order to provide proper care.
- Use the emergency department for emergencies only.
- Tell your PCP as soon as possible after you receive emergency care.
- Inform caregivers about any changes in your Advanced Directive.

HIPAA and Member Privacy Rights

What is Protected Health Information?

In this Notice, protected health information will be written as PHI. The HIPAA Privacy Regulations define protected health information as:

- Information that identifies you or can be used to identify you
- Information that either comes from you or has been created or received by a healthcare provider, a health plan, your employer, or a healthcare clearinghouse
- Information that has to do with your physical or mental health or condition, providing healthcare to you or paying for providing healthcare to you

What are CareFirst CHPMD's Responsibilities to You about Your PHI?

You/your family's PHI is personal. We have rules about keeping this information private. These rules are designed to follow state and federal requirements. CareFirst CHPMD must:

- We are required by law to maintain the privacy and security of your protected health information (PHI).
- We are required to keep your PHI private and secure in all forms, including: hardcopy files, electronic files, as well as verbal communications.
- CareFirst CHPMD is required by law to enable security and privacy features to ensure that these protections are met. Entry into buildings and offices is kept secure and monitored; electronic access to PHI is provided based on the role of the staff member. Staff is trained annually in how to keep your information private during verbal communication.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

Anti-Gag Provisions

Providers participating with CareFirst CHPMD 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 healthcare services, including:

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

Participating Providers agree that a determination by CareFirst CHPMD 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.**

I. The Maryland HealthChoice Program

Assignment and Reassignment of Members

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

- If they move to another county where CareFirst CHPMD 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
- 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
 - 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 CareFirst CHPMD and selects a PCP, CareFirst CHPMD enrolls the member into that practice and mails them a member ID card. CareFirst CHPMD will choose a PCP close to the member's residence if a PCP is not selected.

CareFirst CHPMD is required to provide PCPs with their rosters on a monthly basis. PCP roster information changes daily and should not be used to determine member eligibility. MCO members may change PCPs at any time. Members can call CareFirst CHPMD Member Services Monday–Friday 8 a.m.–5 p.m. at 410-779-9369 or 800-730-8530 to change their PCP.

PCPs may see CareFirst CHPMD 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 CareFirst CHPMD, the PCP may see the CareFirst CHPMD member. However, CareFirst CHPMD 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 CareFirst CHPMD

CareFirst CHPMD performs provider credentialing prior to the inclusion of practitioners in the network and recredentials them on a three (3) year cycle. Our credentialing standards are compliant with NCQA and the State of Maryland requirements.

CareFirst CHPMD uses the credentialing information from the Council for Affordable Quality Healthcare (CAQH) or the state-approved credentialing application.

All primary care offices must undergo a site evaluation as part of their credentialing/recredentialing.

I. The Maryland HealthChoice Program

Providers have the following rights related to the credentialing process:

- To review the information submitted to support your credentialing application
- To correct erroneous information
- To be informed of the status of your credentialing or recredentialing application, upon request
- To be notified if the information obtained during the credentialing process varies substantially from the information provided by the practitioner
- To receive notifications of the credentialing/recredentialing decision within 60 calendar days of the credentialing committee's decision
- To have the credentialing information remain confidential except as otherwise provided by law

Provider Reimbursement

Payment to providers is in accordance with your provider contract with CareFirst CHPMD or with their management groups that contract on your behalf with CareFirst CHPMD. 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. CareFirst CHPMD 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. CareFirst CHPMD 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 B** on page 60 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
- Services performed at a birthing center
- Children with special healthcare needs may self-refer to providers outside of CareFirst CHPMD network under certain conditions. See Section II for additional information

If a provider contracts with CareFirst CHPMD for any of the services listed above the provider must follow our billing and Prior Authorization procedures. Reimbursements will be paid the contracted rate.

I. The Maryland HealthChoice Program

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
- Switched to CareFirst CHPMD 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

Prior Authorization for Healthcare Services

If the previous MCO or company preauthorized services, we will honor the approval if the member calls **410-779-9369** or **800-730-8530**. Under Maryland law, insurers must provide a copy of the Prior Authorization within 10 days of the member's request. There is a time limit for how long we must honor this Prior Authorization. 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
- 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 healthcare provider after the baby is born.

If the member has any questions they should call CareFirst CHPMD Member Services at **410-779-9369** or **800-730-8530** or the state's HealthChoice Help Line at 800-284-4510.

II. Outreach and Support Services, Appointment Scheduling, EPSDT, and Special Populations

MCO Member Outreach and Support Services

CareFirst CHPMD provides notification of enrollment via mail to all new members which includes membership card(s), eligibility start date, and information on how to access healthcare services covered by CareFirst CHPMD.

CareFirst CHPMD also conducts outreach calls and sends reminders for periodic preventive health appointments via mail and secure text messaging. On a monthly basis, CareFirst CHPMD will provide PCPs with a list of members due for preventive visits. Case managers also provide outreach to Special Needs members to ensure that the clinical and psychosocial needs of the member are met. Refer to the Special Populations section.

Providers should contact CareFirst CHPMD for assistance with reaching non-compliant members and those members that are difficult to reach. CareFirst CHPMD outreach resources work collaboratively with the Local Health Departments and the provider to bring members into care. To request member outreach and support services call 410-779-9359 or 800-730-8543.

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). CareFirst CHPMD will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD. See **Attachment C** on page 61 for **NEMT contact information**.

MCO Transportation Assistance

Under certain circumstances, CareFirst CHPMD may provide limited transportation. Members who need transportation assistance can seek services provided through grants to local health departments. See **Attachment C** on page 61 for contact information offered by local health departments.

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 C** on page 61 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 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.

II. Outreach and Support Services, Appointment Scheduling, EPSDT, and Special Populations

- For pregnant and postpartum members 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 CareFirst CHPMD'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 800-888-1965.
- 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 healthcare 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.

Early Periodic Screening Diagnostic and Treatment (EPSDT) Requirements

CareFirst CHPMD 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 childcare according to the EPSDT schedule. If you provide primary care services to individuals under age 21 and are not EPSDT certified, call 410-767-1836. For more information about the HealthyKids/EPSDT Program and Expanded EPSDT services for children under age 21, go to health.maryland.gov/mmcp/epsdt.

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:

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

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

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

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

II. Outreach and Support Services, Appointment Scheduling, EPSDT, and Special Populations

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 CareFirst CHPMD at 410-779-9359 or 800-730-8543. You may concurrently make a written referral to the LHD ACCU by completing the Local Health Services Request form. See **Attachment D** on page 62. Continue to work collaboratively with CareFirst CHPMD 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 healthcare system. You must notify CareFirst CHPMD if these members miss three consecutive appointments or repeatedly do not follow their treatment plan. We will attempt to reach the member and may make a referral to the ACCU to help locate the member and get them into care.

For additional assistance regarding EPSDT, please access this resource: carefirst.az1.qualtrics.com/jfe/form/SV_4Hi5SSyY8Gxhss6.

Special Populations

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

- Pregnant and postpartum members
- Children with special healthcare 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 healthcare services the member receives during the year and serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.

II. Outreach and Support Services, Appointment Scheduling, EPSDT, and Special Populations

- 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 **410-779-9371**.
- 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 CareFirst CHPMD. If a member continues to miss appointments, call CareFirst CHPMD at 410-779-9359 or 800-730-8543. 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 D on page 62** or visit health.maryland.gov/mmcp/HealthChoice/Pages/Home.aspx. The local ACCU staff will work collaboratively with CareFirst CHPMD to contact the member and encourage them to keep appointments and provide guidance on how to effectively use their Medicaid/HealthChoice benefits.

Services for Pregnant and Postpartum Members

Prenatal care providers are key to assuring that pregnant members have access to all available services. Many pregnant members will be new to HealthChoice and will only be enrolled in Medicaid during pregnancy and the postpartum period. Medicaid provides full benefits to these 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: health.maryland.gov/phpa/mch/Pages/MFPP-About.aspx).

CareFirst CHPMD and our providers are responsible for providing pregnancy-related services, which include:

- Comprehensive prenatal, perinatal, and postpartum care (including high-risk specialty care)
- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment form, MDH 4850 (for updated form visit: health.maryland.gov/mmcp/medicaid-mch-initiatives/Documents/MPRA/Maryland%20Prenatal%20Risk%20Assesment%20Fillable%20-%20New%20Language%201.14.25.pdf)
- An individualized plan of care based upon risk assessment and which is modified during the course of care as needed
- Appropriate levels of inpatient care, including emergency transfer of pregnant members and newborns to tertiary care centers
- Case management services
- Prenatal and postpartum counseling and education including basic nutrition education
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant members
- Doula support for prenatal visits, attendance at labor and delivery, and postpartum visits
- Prenatal, postpartum and infant home visits from pregnancy and childbirth up to two or three years of the child's age, depending on the agency conducting home visits

II. Outreach and Support Services, Appointment Scheduling, EPSDT, and Special Populations

The state provides these additional services for pregnant members:

- Special access to substance use disorder treatment within 24 hours of request and intensive outpatient programs that allow for children to accompany their parent.
- Encourage all pregnant members to call the state's Helpline for Pregnant Woman at 800-456-8900. This is especially important for members who are newly eligible or not yet enrolled in Medicaid. If the member is already enrolled in HealthChoice, call us and also instruct them to call our OB Case Management Team at 410-779-9369 or 800-730-8530.

Pregnant members who are already under the care of an out-of-network practitioner qualified in obstetrics may continue with that practitioner if they agree to accept payment from CareFirst CHPMD. 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 CareFirst CHPMD are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcomes. Examples of an appropriate referral include 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 (MPRA) form-MDH 4850. See **Attachment E** on page 63 during the initial visit and submit it to the Local Health Department within 10 days of the initial visit. CareFirst CHPMD 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. CareFirst CHPMD will pay for this- use CPT code H1003 for an "Enriched Maternity Services"—You may only bill for one unit of "Enriched Maternity Services" per visit. Refer pregnant and postpartum members to the WIC Program.
- If under the age of 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 CareFirst CHPMD if a prenatal appointment is not kept within 30 days of the first missed appointment.
- Refer pregnant members to the Maryland Healthy Smiles Dental Program. Members can contact Healthy Smiles at 855-934-9812; TDD: 855-934-9816; Web Portal: **member.mdhealthysmiles.com** if you have questions about dental benefits.
- Refer pregnant and postpartum members in need of diagnosis and treatment for a mental health or substance use disorder to the Behavioral Health System; if indicated, they are required to arrange for substance abuse treatment within 24 hours.
- Educate pregnant members on doula services or refer eligible members for home visits if medically necessary and appropriate.
- Record the member's choice of pediatric provider in the medical record prior to their 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 postpartum member's MCO.

II. Outreach and Support Services, Appointment Scheduling, EPSDT, and Special Populations

Childbirth Related Provisions

Special rules for length of hospital stay following childbirth:

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

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

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

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

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

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

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

We are required to schedule the newborn for a follow-up visit within 2 weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit.

Breast pumps are covered under certain situations for breastfeeding members. Call us at 800-730-8530 or 410-779-9369.

II. Outreach and Support Services, Appointment Scheduling, EPSDT, and Special Populations

Children with Special Healthcare 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 healthcare needs will depend on whether or not the condition that is the basis for the child's special healthcare needs is diagnosed before or after the child's initial enrollment in CareFirst CHPMD. 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 CareFirst CHPMD and we approve the services as medically necessary.

Established Member: A child who is already enrolled in CareFirst CHPMD when diagnosed as having a special healthcare 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 healthcare needs CareFirst CHPMD 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 healthcare 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 healthcare 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 healthcare needs to access out-of-network specialty providers under certain circumstances. We log any complaints made to the state or to CareFirst CHPMD about a child who is denied 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 CareFirst CHPMD 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.

II. Outreach and Support Services, Appointment Scheduling, EPSDT, and Special Populations

- 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 member's 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 healthcare services.

CareFirst CHPMD 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 healthcare 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 CareFirst CHPMD or they may receive services through the traditional Medicaid fee-for-service program. They cannot be in both an MCO and REM. **See Attachment A** on page 51 for the list of qualifying diagnosis and a full explanation of the referral process.

III. HealthChoice Benefits and Services

MCO Benefits and Services Overview

CareFirst CHPMD 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 CareFirst CHPMD 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 CareFirst CHPMD case management program. Please refer to **Attachment G** on page 67 for more information.

CareFirst CHPMD offers Case Management to members who have had a critical medical event, been diagnosed with a chronic illness and have multiple illnesses or complications. Case Managers help members:

- Set goals and make care plans for continuous outreach activities
- Ensure care is accessible, when needed

- Make sure members have what they need to get care, such as transportation
- Help members manage their symptoms
- Answer questions about the member's health and healthcare
- Provide members with up-to-date health information
- Visits the member's home or doctor's office to provide additional assistance

To contact a member of CareFirst CHPMD Case Management team, call member services at 410-779-9369 or 800-730-8530 (TTY: 711), Monday–Friday, 8 a.m.–5 p.m. or email us at CHPMDHealthServices@carefirst.com.

Clinical Trial Items and Services

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

Dental Services

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

Visit health.maryland.gov/mmcp/pages/maryland-healthy-smiles-dental-program.aspx to learn more.

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
 - Diagnostic reagent strips and tablets used for testing for ketone and glucose in urine and glucose in blood

III. HealthChoice Benefits and Services

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

Diagnostic and Laboratory Services

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

Dialysis Services

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

Disease Management

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

- Diabetes
- Hypertension
- Asthma
- CHF (Congestive Heart Failure)
- COPD (Chronic Obstructive Pulmonary Disease)
- Hypercholesterolemia

Refer to Section Disease Management:
Attachment H: page 68.

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 CareFirst CHPMD, 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, Diagnostic 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
- 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

III. HealthChoice Benefits and Services

to treat the identified condition and all must be covered subject to limitations only based on medical necessity. These include such services as:

- Chiropractic services
- Nutrition counseling
- Private duty nursing services
- Durable medical equipment including assistive devices
- 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-Affirming Services

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

Habilitation Services

We cover habilitation services when medically necessary for certain adults who are eligible for Medicaid under the Affordable Care Act (ACA). These services include physical therapy, occupational therapy, and speech therapy. If you have questions about which adults are eligible, call 410-779-9369 or 800-730-8530.

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
- Medical supplies used in a home health visit

Hospice Care Services

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

Inpatient Hospital Services

We cover inpatient hospital services. CareFirst CHPMD is not responsible for payment of any remaining days of a hospital admission that began prior to the individual's enrollment in our MCO.

III. HealthChoice Benefits and Services

We are, however, responsible for reimbursement of professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

Mobile Integrated Community Health

CareFirst CHPMD covers mobile integrated health (MIH) services provided by approved Emergency Medical Services (EMS) agencies for eligible adults. CareFirst CHPMD will contract with Jurisdictional Emergency Medical Services Operational Programs (JEMSOPs) that are active in CareFirst CHPMD's covered service areas to provide MIH services to Medicaid participants who are 18 years of age or older and enrolled in an MIH program. JEMSOPs will provide MIH services in accordance with medical protocols adopted by Maryland Institute for Emergency Medical Services Systems (MIEMSS) and must deliver MIH services—community-based preventative, primary, chronic, pre-admission, or post-admission healthcare services—in a participant's home or other community-based setting. Services delivered to members will be billed to CareFirst CHPMD.

Nursing Facility Services

For members that were enrolled in CareFirst CHPMD prior to admission to a nursing facility, chronic hospital or chronic rehabilitation hospital and who meet the State's level of care (LOC) criteria, CareFirst CHPMD 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 age 21, rehabilitative services are covered by CareFirst CHPMD 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 FDA 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 copays for children, pregnant members, individuals in nursing facilities or hospice or birth control. For drugs covered by the State, such as behavioral health drugs, pharmacy copays are \$1 for generic drugs, preferred brand-name drugs, and HIV/AIDS and \$3 for brand-name drugs.

Plastic and Restorative Surgery

We cover these services when the service will correct a deformity from disease, trauma, congenital, or developmental anomalies or to restore body functions. **Cosmetic 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 **Attachment F** on page 66 for **Prenatal/Postpartum Programs**.

To contact an OB Case Manager, please call 800-730-8543 or 410-779-9359.

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 800-888-1965, Monday–Friday 8 a.m.–6 p.m.

III. HealthChoice Benefits and Services

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
- 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 healthcare services
- 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. Telemedicine and Remote Patient Monitoring is offered to members who consent to participate in specific Case Management Services.

Refer to **Attachment I** on page 69 for Telemedicine and Remote Patient Monitoring.

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.

Optional Services Covered By CareFirst CHPMD

In addition to those services previously noted CareFirst CHPMD 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.

Refer to **Attachment J** on page 70 for additional services offered by CareFirst CHPMD.

Medicaid Benefits Covered By The State—Not Covered by CareFirst CHPMD

- The State covers dental services for all members who receive full Medicaid benefits. The Maryland Healthy Smiles Dental Program is responsible for routine preventative services, restorative service, and orthodontia. Orthodontia must meet certain criteria and requires Prior Authorization by SKYGEN USA, the State's ASO. SKYGEN USA assigns members to a dentist and issues a dental Healthy Smiles ID card. However, the member may go to any Healthy Smiles participating dentist. If you have questions about dental benefits, call 855-934-9812.

III. HealthChoice Benefits and Services

- Outpatient rehabilitative services for children under age 21
- Specialty mental health and substance use disorders covered by the Specialty Behavioral Health System
- Intermediate Care Facilities for Individuals with Intellectual Disabilities or Persons with developmental disabilities
- Personal care services
- Medical day care services, for adults and children
- Abortions (covered under limited circumstances—no Federal funds are used—claims are paid through the Maryland Medical Care Program). If a member was determined eligible for Medicaid based on their pregnancy, they are not eligible for abortion services
- Emergency transportation (billed by local EMS)
- Non-emergency transportation services provided through grants to local governments
- Services provided to members participating in the State's Health Home Program
- Certain high-cost low-volume drugs
- 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 CareFirst CHPMD 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 U.S.
- Immunizations for travel outside the U.S.
- Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis
- Private hospital room is not covered unless medically necessary or no other room is available
- Autopsies
- Private duty nursing services for adults 21 years old and older
- Orthodontia is not covered by the MCO but may be covered by Healthy Smiles when the member is under 21 and scores at least 15 points on the Handicapping Labio-lingual Deviations Index No. 4 and the condition causes dysfunction
- Ovulation stimulants, in vitro fertilization, ovum transplants, and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer or cryogenic, or other preservation techniques used in these or similar
- Reversal of voluntary sterilization procedures;
- Medications for the treatment of sexual dysfunction

Benefit Limitations

CareFirst CHPMD 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 healthcare practitioner (i.e., by a person who is licensed, certified or otherwise legally authorized to provide healthcare services in Maryland or a contiguous state)
- Services that are beyond the scope of practice of the healthcare practitioner performing the service

III. HealthChoice Benefits and Services

- MCOs are not permitted to cover abortions. We are required to assist members in locating these services and we are responsible for related services (sonograms, lab work, but the abortion procedure, when conditions are met, must be billed to Medicaid fee-for service)
- Non-legend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, and minerals or other minerals in the formulation when the member is under 12 years old and non-legend drugs other than insulin and enteric-coated aspirin for arthritis
- Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy
- Diet and exercise programs for weight loss except when medically necessary
- Lifestyle improvements (physical fitness programs and nutrition counseling, unless specified)
- MCOs do not cover emergency transportation services and are not required to cover non-emergency transportation services (NEMT). However, CareFirst CHPMD provides transportation assistance (see Attachment J on page 70) and members may have additional access to non-emergency transportation through the local health department.

IV. Prior Authorization and Member Complaint, Grievance, and Appeal Procedures

Services Requiring Prior Authorization

For Elective Inpatient Admissions, CareFirst CHPMD adheres to COMAR 10.09.92 where hospitals will request Prior Authorization for inpatient stays when such services cannot be provided on an outpatient basis or can only be provided in a facility that is licensed as an acute hospital. Hospital staff will obtain Prior Authorization before the member is admitted by providing all of the following information:

- Member's medical history and physical and
- Sufficient clinical information or documentation that supports the medical necessity of the acute inpatient admission

CareFirst CHPMD is not responsible for payment of any remaining days of a hospital admission that began prior to the individual's enrollment in our MCO. CareFirst CHPMD however is responsible for reimbursement of professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

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

Any outpatient services being rendered by an out-of-network provider and/or facility, including ambulatory care facilities or freestanding facilities requires Prior Authorization.

Services Requiring Prior Authorization

Home visits

Concurrent or additional home visits after the initial evaluation visit for:

- Skilled Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy

- Home Health Aide
- Home Infusion
- Hospice
- Private Duty Nursing under 21 years of age
- Social Work

In-patient admissions

All elective and emergent admissions, including skilled nursing facility and long-term care facility.

Outpatient

- Acne Surgery
- Audiology
- Bariatric Surgery
- Biofeedback
- Bone Marrow Biopsy, Harvesting, Transplantation
- Bone Stimulation
- Cell Harvesting (stem cell, t-cell)
- Chemodenervation
- Chemical Peels, Dermabrasions
- Clinical Trials
- Cosmetic Surgery
- DME/DMS Purchase over \$500 and all Rentals and/or Repairs
- Facet Joint Injections
- Hearing Aids
- Meals Post-Discharge Hospital or SNF
- Nerve Block
- Neurostimulation
- Outpatient therapy
 - Physical, occupational, and speech therapy
- Oral and Maxillofacial Surgery
- Pain Management Procedures—Joint, Trigger Point, and Spinal Injections
- Pharmacy see Carve Outs/Delegation below
- Plastic Surgery

IV. Prior Authorization and Member Complaint, Grievance, and Appeal Procedures

- Radiology services performed by out-patient hospital radiology providers including:
 - CT
 - CTA
 - Digital X-ray
 - MRI/MRA
 - Nuclear Stress Test
 - PET
 - Ultrasound
- Reconstructions, Reductions, Implantations
- Skin/Subcutaneous Tissue Excisions, Removal of Lesions
- Sterilization
- Telemedicine and remote patient monitoring
- Vein Ablation Therapy, Ligation, or Stripping

Rehabilitative therapies

- Concurrent or additional visits after the Initial Evaluation visit for Seating Evaluations, Pulmonary and/or Cardiac Rehab
- See Carve Outs/Delegation for under 21

Medical injectables

This list of medical injectables and their related biosimilars, all require Prior Authorization.

Carve Outs/Delegation

Maryland Medicaid (CareFirst CHPMD)

Pharmacy

- Member Services: 855-566-8397
- Prior Authorization: 877-418-4133

Prior Authorization for formulary and non-formulary products requiring: PA (Prior Authorization), QL (Quantity Limit), or ST (Step Therapy)

Visit carefirst.com/medicaid to access the formulary drug list online. To access the lists, click on *Providers* and select *Drug List (Formulary) Updates*.

Mental Health/Substance Use Disorder

Carelon Behavioral Health: 800-888-1965

Dental

- Healthy Smiles: 855-934-9812
- Visit health.maryland.gov/mmcp/pages/maryland-healthy-smiles-dental-program.aspx to learn more.

Vision

Superior Vision: 877-235-5317

Non-Emergent Medical Transportation

Contact the local Health Department (see **Attachment C** on page 61 for contact information).

Maryland Medical Assistance Beneficiary Hotline: 800-492-5231

- Abortions
- Emergency transportation
- HIV/AIDS services (viral load, genotypic, phenotypic or other resistance testing)
- Medical day services
- Outpatient PT, OT, and ST for recipients under the age of 21
- Personal care services
- Speech augmentation

Services Not Requiring Prior Authorization

CareFirst CHPMD does not require authorization for most office and routine patient ambulatory based services provided by an in-network provider and/or an in-network freestanding facility.

- Acupuncture
- Cardiac Cath
- Chemotherapy (exceptions listed under authorization required section)
- Chiropractic Services (under age 21)
- Cholecystectomy (Laparoscopic)
- Colonoscopy
- Cystoscopy (Cystectomy, w/Urethroscopy, w/Lithotripsy)
- Diabetic education
 - Self-management training
 - Nutritional counseling
 - Screening and supplies

IV. Prior Authorization and Member Complaint, Grievance, and Appeal Procedures

- Dialysis
 - DME/DMS purchase less than \$500
 - Endoscopy (EGD, ERCP)
 - Emergency/Urgent Care (within U.S.)
 - Hearing screening
 - Hysteroscopy/Hysterectomy
 - Laboratory/Pathology
 - Nutrition counseling
 - Observation
 - Office visits for physician or practitioner services
 - Primary Care including wellness and/or Preventative Visits
 - Immunizations/Vaccinations, ESPDT
 - Specialist consultations/evaluations
 - Pain management consultations/evaluations
 - Podiatry* including diabetic care services and routine foot care for vascular disease affecting lower extremities
 - Prenatal and post-partum
 - Radiation therapy
 - Radiology screenings including:
 - Bone density, mammograms, AAA ultrasound, OB ultrasound, low dose lung CT
 - Radiology services performed by freestanding radiology network providers including:
 - CT, CTA, Digital X-ray, MRI, MRA, Nuclear Stress Test, PET, and Ultrasound
 - Sleep Studies
- For step-by-step instructions, access the following resources:
 - [Accessing and Registering for CareFirst Direct](#)
 - [Entering Authorizations in the CareFirst Provider Portal](#)
 - [Prior Authorization Lookup Tool Walk-Through](#)
 - **Fax Option—should only be utilized when CareFirst Provider Portal (CareFirst Direct) is not available**
 - 410-779-9336, 443-552-7407 or 443-552-7408
 - Via telephone at 410-779-9359 or 800-730-8543
 - Submit with the appropriate CareFirst CHPMD form

All prior authorization requests must be submitted with sufficient clinical documentation. To ensure timeliness of prior authorization requests, documentation submitted shall include, but is not limited to:

- Current medical health status
- Treatment received to date
- A proposed treatment plan, when applicable

Upon receipt of the above prior authorization documentation, CareFirst CHPMD will verify member eligibility and benefits. Determinations are made based on the member's healthcare needs and medical history in conjunction with nationally recognized, evidenced-based clinical guidelines. If medical necessity criteria are not met during the initial review, the provider may discuss the case with a CareFirst CHPMD physician prior to the determination. If the prior authorization request is denied, the appropriate adverse determination letter, including the member's appeal rights, will be mailed to the requesting provider, member's PCP and the member.

Prior Authorization Procedures

CareFirst CHPMD requires prior authorization for all inpatient admissions and certain outpatient services. To request prior authorization, the referring or servicing provider of the facility rendering the service can submit the request in one of the following ways:

- **Preferred** via electronic entry using the CareFirst Provider Portal (CareFirst Direct)
 - Log onto provider.carefirst.com
 - Once logged in, select the 'Prior Authorization/Notifications' tab
 - Select 'Start' within the 'Medical' box

Inpatient Admissions and Concurrent Review

For Inpatient Admissions and Concurrent Review, CareFirst CHPMD adheres to COMAR 10.09.92 where as long as the member remains hospitalized, concurrent review will be performed based on the member's diagnosis and medical condition.

IV. Prior Authorization and Member Complaint, Grievance, and Appeal Procedures

For emergency inpatient admissions the concurrent review process will be initiated by the hospital within the first 48 hours of the admission or by the next business day.

For elective inpatient admissions the concurrent review process will be initiated by the hospital before the termination of the days previously authorized by CareFirst CHPMD.

For emergency and elective inpatient admissions, the hospital will forward sufficient clinical documentation to CareFirst CHPMD's Utilization Review Department that supports the need for continuing acute care. Documentation submitted shall include, but is not limited to:

- Current medical health status
- Treatment received to date
- A proposed treatment plan for the continued stay

Providing a hospital face sheet only or a completed CareFirst CHPMD Prior Authorization Form only is not sufficient clinical documentation to initiate concurrent review for an inpatient admission.

Reviews for all behavioral health related inpatient admissions need to be directed to the behavioral health ASO to request an authorization for inpatient services described in COMAR 10.09.70.02D and Attachment F.

Period of Prior Authorization

Prior Authorization numbers are valid for the date of service authorized or for a period not to exceed 30 days after the date of service authorized. The member must be eligible for Medicaid and enrolled in CareFirst CHPMD on each date of service. For information about how to verify member eligibility call 410-779-9359 or 800-730-8543.

Prior Authorization and Coordination of Benefits

CareFirst CHPMD may not refuse to a prior authorization 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. Prior authorization is not a guarantee of payment. Except for prenatal care and Healthy Kids/EPSTD 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
- Not primarily for the convenience of the member, the member's family, or the provider

Clinical Guidelines

CareFirst CHPMD's Provider Advisory Committee (PAC) reviews and approves the Clinical Guidelines yearly. The latest Clinical Guidelines are available at carefirst.com/medicaid under the *For Providers* section.

Timeliness of Decisions and Notifications to Providers and Members

CareFirst CHPMD makes Prior Authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the Maryland Department of Health, CareFirst CHPMD 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
- Covered outpatient drug authorizations—within 24 hours by telephone to either authorize the drug or request additional clinical information

IV. Prior Authorization and Member Complaint, Grievance, and Appeal Procedures

CareFirst CHPMD 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, CareFirst CHPMD will assign a Prior Authorization number, which refers to and documents the approval. CareFirst CHPMD 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. CareFirst CHPMD makes such decisions on a case-by-case basis.

Overview of Member Complaint, Grievance, and Appeal Processes

Our MCO member services line, 410-779-9369 or 800-730-8530 operates 8 a.m.–5 p.m. Member Services resolves or properly refers members' inquiries or complaints to the State or other agencies. CareFirst CHPMD 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 CareFirst CHPMD website at carefirst.com/medicaid.

Members or their authorized representatives can file an appeal or a grievance with CareFirst CHPMD 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 CareFirst CHPMD, free of charge, to help with their appeal by calling 410-779-9369 or 800-730-8530:

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

CareFirst CHPMD 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
- Members or providers making complaints against CareFirst CHPMD or the Department

CareFirst CHPMD 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 CareFirst CHPMD.

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. CareFirst CHPMD 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.

IV. Prior Authorization and Member Complaint, Grievance, and Appeal Procedures

Examples of reasons to file an administrative grievance include:

- The member's provider's office was dirty, understaffed, or difficult to access.
- The provider was rude or unprofessional.
- The member cannot find a conveniently located provider for their healthcare needs.
- The member is dissatisfied with the help he/she received from the provider's staff or CareFirst CHPMD.

Examples of reasons to file a medical grievance include:

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

Grievances may be filed at any time with CareFirst CHPMD orally or in writing by the member or their authorized representative, including providers. CareFirst CHPMD 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
- 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, CareFirst CHPMD 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:

- CareFirst CHPMD 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
- CareFirst CHPMD 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
- CareFirst CHPMD denies all or part of payment for a service a member has received and the denial was not related to the claim being "clean"

IV. Prior Authorization and Member Complaint, Grievance, and Appeal Procedures

- CareFirst CHPMD fails to provide services in a timely manner, as defined by the Department (for example, it takes too long to authorize a service a member or their provider requested)
- CareFirst CHPMD 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:

- CareFirst CHPMD'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 CareFirst CHPMD'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 CareFirst CHPMD, 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 800-284-4510. Providers may call the State's HealthChoice Provider Help Line at 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 CareFirst CHPMD make a decision, they may call CareFirst CHPMD at **410-779-9369** or **800-730-8530**.

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

When reviewing the member's appeal we will:

- Use doctors with appropriate clinical expertise in treating the member's condition or disease
- Not use the same MCO staff to review the appeal who denied the original request for service
- 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. CareFirst CHPMD 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 CareFirst CHPMD 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. CareFirst CHPMD will make a reasonable effort to provide verbal notification and will send written notification **within two (2) calendar days**.

IV. Prior Authorization and Member Complaint, Grievance, and Appeal Procedures

Once we complete our review, we will send the member a letter letting them know our decision. CareFirst CHPMD 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, CareFirst CHPMD 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 **410-779-9369** or **800-730-8530** 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 pending review.

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 CareFirst CHPMD 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 CareFirst CHPMD 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 CareFirst CHPMD. If CareFirst CHPMD upholds the denial, the member may appeal to the Office of Administrative Hearings (OAH) by contacting the HealthChoice Help Line at 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, CareFirst CHPMD 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 CareFirst CHPMD direct them to call the State's HealthChoice Help Line at 800-284-4510. Providers can contact the HealthChoice Provider Line at 800-766-8692.

V. Pharmacy Management

Pharmacy Benefit Management

CareFirst CHPMD 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. This includes 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 Prior Authorization to ensure medical necessity for specific therapies. For formulary drugs requiring Prior Authorization, 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, and minerals or other minerals in formulation, for members under age 12
- Formulas for genetic abnormalities
- 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

Mail Order Prescriptions

We cannot require a member to use mail-order but we do offer CVS mail-order pharmacy services for certain drugs.

Specialty Pharmacy Services

For specialty pharmacy services CareFirst CHPMD contracts with **CVS Specialty Pharmacy and select CareFirst Pharmacies.**

CareFirst CHPMD is responsible for formulary development, drug utilization review, and Prior Authorization. CareFirst CHPMD'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.

V. Pharmacy Management

Prescription and Drug Formulary

Check the current CareFirst CHPMD formulary at carefirst.com/medicaid in the *Providers* section, before writing a prescription for either prescription or over-the-counter drugs, CareFirst CHPMD 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 client.formularynavigator.com/Search.aspx?siteCode=9381489506.

Prescription Copays

There are no copays for children under 21, pregnant members, individuals in a nursing facility or hospice, or for family planning. CareFirst CHPMD requires a copay \$1 for generics and a \$3 copay for brand-name prescription drugs.

Over-the-Counter Products

The previous \$15 per member per quarter limit will no longer apply and members can now obtain majority of Over-the-counter (OTC) drugs through the pharmacy benefit formulary. OTC drugs will be available at formulary cost share amounts: \$0, \$1, or \$3, depending on the drug. Members can reference the comprehensive formulary document for a list of covered OTC drugs on our website: carefirst.com/medicaid/members/drug-listformulary-updates.html.

Injectables and Non-Formulary Medications Requiring Prior-Authorization

All non-formulary medications and non-self-administered injectables requires a Prior Authorization. Please go to our website for the most up-to-date information:

List of drugs requiring Prior Authorization, including upcoming formulary changes: carefirst.com/medicaid/members/drug-listformulary-updates.html.

More information regarding the Prior Authorization process: carefirst.com/medicaid/provider/prior-authorizations.html.

Prior Authorization Process

CareFirst CHPMD require Prior Authorization on certain drugs on the formulary and all non-formulary drugs. CVS administrates our Prior Authorization program.

Contact CVS for a PA (Prior Authorization), QL (Quantity Limit), ST (Step Therapy), or Medication Exception review. You may reach CVS in one of the following ways:

1. **Call** CVS CareFirst CHPMD PA line at 877-418-4133. Hours are Monday–Friday, 9 a.m.–7 p.m., Saturday–Sunday 8 a.m.–5:30 p.m., closed Holidays. Please be prepared to provide the clinical reviewer supporting medication documentation during this call. Or, when you call CVS choose Option 1 to obtain a CVS Clinical Prior Authorization Criteria Request Form to complete. This form can be used to begin the medication exception process.
2. **Fax** the completed Formulary Exception/ Prior Authorization Request Form with clinical information to CVS at 855-762-5205.
3. **Submit** an electronic PA request to CVS through CoverMyMeds.

More information is available on our website at carefirst.com/medicaid in *For Providers* section.

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

Step Therapy and Quantity Limits

CareFirst CHPMD has ST and QL on certain drugs on the formulary. Follow the Prior Authorization Process above for an exception to these requirements.

Maryland Prescription Drug Monitoring Program

CareFirst CHPMD 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.

V. Pharmacy Management

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 crisphealth.org/applications/prescription-drug-monitoring-program-pdmp 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 410-779-9369 or 800-730-8530 if a member is having difficulty filling a prescription. The CMC program is particularly concerned with appropriate utilization of opioids and benzodiazepines. CareFirst CHPMD will work with the State in these efforts and adhere to the State's Opioid Prior Authorization criteria.

Maryland Opioid Prescribing Guidance and Policies

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

Policy

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

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

Naloxone should be prescribed to patients that meet certain risk factors. Both the CDC and Centers for Medicaid, and Medicare Services have emphasized that clinicians should incorporate strategies to mitigate the risk of overdose when prescribing opioids.² We encourage providers to

¹ Instructions on calculating MME is available at https://www.cdc.gov/overdose-prevention/?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf.

V. Pharmacy Management

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 who is identified as having a substance use disorder to a substance use treatment program.

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 with 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: health.maryland.gov/pophealth/Pages/LHD-Programs-and-Services--SBIRT.aspx.

Patients Identified with Substance Use Disorder Should be Referred to Substance Use Treatment. Maryland Medicaid administers specialty behavioral health services through Carelon Behavioral Health of Maryland. If you need assistance in locating a substance use treatment provider, Carelon 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.carelonbh.com.

Providers should use the PDMP 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: health.maryland.gov/pdmp. If you are not already a registered CRISP user you can register for free at crispie.my.site.com/PDMP/s/. PDMP usage is highly encouraged for all CDS prescribers and is mandatory to check patients CDS prescriptions if prescribing CDS at least every 90 days (by law).

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

² CDC guidance: https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1.htm_w; 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>.

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 CareFirst CHPMD before rendering services.

- 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 CareFirst CHPMD

As a Participating Provider, you have agreed to a fee-for-service arrangement as defined in your Participating Agreement with CareFirst CHPMD. The rate established in your Participating Agreement constitutes payment in full for covered services. Members may not be balanced billed for the difference between the actual billed amount for covered services and your contracted reimbursement rate.

Claims for CareFirst CHPMD members may be submitted in one of the following methods:

- Electronically (preferred method) through our clearinghouse: For more information, Providers can visit Availity or call at 800-282-454—Payor ID 45281
- Paper using a CMS 1500 or UB04. Mail paper claims to:
CareFirst CHPMD
P.O. Box 14362
Lexington, KY 40512

All claims, whether paper or electronic, should be submitted using standard clean claim requirements including, but not limited to:

- Member name and address
- Member ID number
- Place of service
- Provider name
- Provider NPI
- Diagnosis (ICD-10) code(s) and description(s)
- Applicable CPT/Revenue/HCPSC codes
- Applicable modifiers

Claims must be filed within 180 days of the date of service.

VI. Claims Submission, Provider Appeals, Quality Initiatives, Provider Performance Data and Pay for Performance

If you would like additional information relative to CareFirst CHPMD claims submission guidelines, please visit our website at carefirst.com/medicaid.

CareFirst CHPMD offers ePayment which replaces paper-based claims payments with electronic fund transfer (EFT) payments that are directly deposited into your bank account. Once enrolled, you will be able to search, view, and print images of the Electronic Remittance Advice (ERA) or download HIPAA formatted 835 files to simplify payment posting. For more information, Providers can visit Availity or call at 800 282-4548—Payor ID 45281 or visit the website at carefirst.com/medicaid/provider/claims.html.

Billing Inquiries

If you have billing inquiries, please visit our website at carefirst.com/medicaid/provider/claims.html.

Provider Appeal of CareFirst CHPMD Claim Denial

A provider may appeal a decision by CareFirst CHPMD to deny or partially deny payment of services rendered. Providers must file an appeal within 90 business days from the date of the denial of payment. Providers have at least 15 business days from the date of denial to file each subsequent level of appeal.

CareFirst CHPMD will acknowledge an appeal within five (5) business days of receipt. CareFirst CHPMD will resolve an appeal in writing within 90 business days of receipt.

CareFirst CHPMD will provide a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. CareFirst CHPMD will permit the provider the opportunity before and during the appeal process to examine the appeal case file including medical records and any other documents and records. When reviewing the appeal, CareFirst CHPMD will consider a full investigation of the substance of the appeal including any clinical aspects. CareFirst CHPMD will appoint a new reviewer, who was not involved in the initial determination, is not a subordinate of any person involved with the initial determination, and is of the same or similar specialty as typically treats the medical condition or performs the procedure on appeals of an adverse determination.

Notification of the Outcome of Appeal

When the outcome of the appeal is known, the results and the date of the appeal resolution will be provided in writing to the provider. The resolution letter will contain the rationale for the determination and the opportunity for a second-level appeal.

Second-Level Appeal

At a second-level review, Provider Claim Appeal disputes related to a denial based on medical necessity that remain unresolved subsequent to the Provider Appeal is reviewed by a physician contracted by CareFirst CHPMD, who is not a Network Provider. The contracted physician resolving the Claim Payment Appeal dispute holds the same specialty or a related specialty as the Appealing Provider. The contracted physician's determination is binding by CareFirst CHPMD and the Appealing Provider.

The provider must notify CareFirst CHPMD of their request for a second level appeal within fifteen (15) business days of the date of the letter nothing the outcome of the appeal. CareFirst CHPMD will acknowledge the request for a second level appeal in writing within five (5) days of receipt. A meeting between the CareFirst CHPMD Chief Executive Officer or designee, the provider, and a provider who was not involved in the case is scheduled. CareFirst CHPMD appoints a new reviewer who was not involved with the initial determination, is not a subordinate of any person involved in the initial appeal determination, and is of the same or similar specialty as typically treats the medical condition or performs the procedure. The selected reviewer receives all documentation used in the initial appeal process for review and any additional information provided for the second-level review. During the informal meeting the appellant, the reviewer, and the Chief Executive Officer, or his/her designee, review the evidence and a determination is made by the reviewer. The appellant is notified in writing of the decision. This is the final level of appeal with CareFirst CHPMD.

VI. Claims Submission, Provider Appeals, Quality Initiatives, Provider Performance Data, and Pay for Performance

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 CareFirst CHPMD but MDH cannot compel CareFirst CHPMD to pay claims that CareFirst CHPMD 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 health.maryland.gov/mmcp/HealthChoice/Pages/independent-review.aspx. The IRO does not accept cases for review which involve disputes between the Behavioral Health ASO and CareFirst CHPMD.

MCO Quality Initiatives

CareFirst CHPMD incorporates a quality improvement philosophy throughout the organization's structures and services. CareFirst CHPMD uses nationally recognized quality measures as well as develops internal measures to continuously evaluate the performance of all health plan functions. Based on these measures the health plan reports its performance to all stakeholders including providers, members, and regulators. Improvement opportunities are identified and quality initiatives are developed and tracked by the health plans quality committee structure.

CareFirst CHPMD recognizes that its network providers are integral in the quality improvement process and in the delivery of quality care and service to members. CareFirst CHPMD seeks provider input and participation in all its quality initiatives including initiatives to:

- Monitor and evaluate patient care and services to ensure care provided by CareFirst CHPMD providers meets the requirements of good medical practice and is positively perceived by health plan members
- Review of the quality and utilization of clinical care and service, including inpatient and outpatient care provided by hospitals, practitioners, healthcare professionals, and ancillary providers
- Identify and meet the health and wellness needs of CareFirst CHPMD's diverse membership through a comprehensive population health management strategy
- Outreach to members in a culturally competent manner to provide health education and empower them in their healthcare
- Promptly identify and analyze opportunities for improvement in the delivery of care and services through targeted Performance Improvement Projects (PIP)
- Coordinate quality improvement, risk management, and patient safety activities including the collection of quality of care complaints
- Maintain compliance with local, state, and federal regulatory requirements as well as NCQA accreditation standards
- Provide continuity of care between providers, across care settings and between medical and behavioral healthcare services
- Increase the accessibility and availability of care especially to members with special needs

CareFirst CHPMD monitors quality indicators to evaluate all quality initiatives. Indicators are designed to reveal trends and performance opportunities in specific areas and facilitate plan-wide improvement. To this end, a variety of care and service indicators are derived from as many sources as appropriate. The quality indicators are measurable, based on reasonable research and use current and accepted quality methodologies. Examples of monitoring indicators may include clinical and service measures such as HEDIS® and CAHPS® and appeals and grievances. Additionally, CareFirst CHPMD will monitor utilization data to measure the effective and appropriate use of healthcare resources.

VI. Claims Submission, Provider Appeals, Quality Initiatives, Provider Performance Data, and Pay for Performance

Performance on these quality indicators is analyzed within the CareFirst CHPMD quality committee structure through the development of written Quality Improvement Analyses and the annual Quality Improvement Evaluation. Provider feedback and input is essential throughout this committee structure. CareFirst CHPMD encourages providers who want to take an active role in the quality improvement program to join the Provider Advisory Committee. Providers on this committee meet with health plan staff quarterly to provide advice and oversight of the CareFirst CHPMD quality improvement program. The Provider Advisory Committee reports directly to CareFirst CHPMD's Quality Improvement Committee.

For additional information on current health plan goals and objectives, as well as recent quality measure scores, visit the Quality Improvement Program section of our website.

Provider Performance Data

CareFirst CHPMD produces a "Gaps in Care" report that tracks the Provider's member-level and measure-level prospective performance against HEDIS and MDH Quality Measures. This report is distributed to the Provider Network monthly. The member-level results are displayed along with demographic details including the member's phone for outreach and PCP attribution details. A detailed summary of the measures represented in the report is included.

CareFirst Population Health Consultants are continuously engaging with the Provider Network to help them utilize the Gaps in Care reporting to improve their performance and patient outcomes. They look for opportunities to collaborate with Providers towards that goal throughout the year.

For more information, Providers can contact 410-779-9359 or 800-730-8543 and ask to speak with the Quality Department or they can contact their CareFirst Population Health Consultant.

Pay for Performance

CareFirst CHPMD provides a provider incentive program for provider groups who are treating 200 or more members. The incentive program is tiered to include incentives for small, medium, and large groups based on the member panel sizes. The incentive program details are provided to groups by the Population Health Consultants directly to each eligible group based on their panel size.

Generally, the incentive programs include a 4 Star performance incentive across all the designated measures. A 4-Star performance is generally equivalent to the 75th percentile of performance by all Medicaid managed care plans nationally, as reported by NCQA. For smaller panel-size groups, the incentive can include an incentive for achieving a well visit rate at higher than 50% of eligible members.

VII. Provider Services and Responsibilities

Overview of CareFirst CHPMD Provider Services and Responsibilities

CareFirst CHPMD encourages the use of self-service tools to obtain information regarding routine inquiries. Utilization of self-service tools allows our Customer Service Advocates (CSAs) to focus on issues requiring additional interventions than are available through self-service.

In-network providers can use our Provider Portal to access information 24/7. Within the Provider Portal you can check eligibility, benefits, claims status, submit prior authorizations, update your demographic information and more. For more information and to register for access, please navigate to the Provider Portal page on the CareFirst CHPMD website at carefirst.com/medicaid/provider/provider-portal.html.

Provider Services CSAs can address issues that cannot be resolved through self-service tools. Provider Services may be reached at 410-779-9359 or 800-730-8543.

CareFirst CHPMD also has a Provider Relations Department that offers support such as:

- Initial and ongoing provider orientation, education, and training
- Communicating to providers for health plan and specific program changes
- Engaging providers in quality initiatives
- Disseminating provider resources designed to help service our members

If you need help with any of the topics mentioned above, visit carefirst.com/providersupport for assistance.

Provider Website

The CareFirst CHPMD provider website (carefirst.com/medicaid/provider/provider-overview.html) includes helpful information and resources to help you find what you need in support of your patients, such as:

- Claims Information
- Prior Authorizations

- How to Keep your Provider Data Accurate
- Clinical Practice Guidelines
- Direct Access to Provider Portals
- Newsletters and Alerts
- Pharmacy information
- Provider Manual
- Quality Toolkit

Learning and Engagement Center

The Learning and Engagement Center offers a flexible, free, and engaging training experience for providers of all experience levels. The Learning and Engagement Center helps providers and their staff manage tasks like identifying CareFirst CHPMD members, understanding claims and billing procedures, and using various support tools.

Visit the Learning and Engagement Center online at carefirst.com/learning. There is a section dedicated to our Government Programs providers within the On-Demand Training tab. You can access it directly by going to carefirst.com/learning/on-demand-training/on-demand-training-government-programs.html.

In addition, you can access the Learning and Engagement Center from the CareFirst CHPMD provider home page in the Provider Resources section on the toolbar.

Training Options Available

You can access live and recorded webinars, on-demand training modules, microlearning modules, health equity courses, and more. Provider Relations offers quarterly live webinar opportunities for CareFirst CHPMD Providers. Access this page to enroll today, carefirst.com/learning/webinars/webinars.html.

Re-Credentialing

CareFirst CHPMD recredentials practitioners on a three (3) year cycle. Our credentialing standards are compliant with NCQA and the State of Maryland requirements. For more information refer to section Credentialing and Contracting.

VII. Provider Services and Responsibilities

Ongoing Monitoring of Sanctions

Between recredentialing cycles, CareFirst CHPMD monitors state licensing boards and other sources for sanctions and disciplinary actions. Reports are reviewed by the CareFirst Medical Director who may request further review by the CAC. The Medical Director may request additional information from the practitioner.

For more information on our credentialing process, visit carefirst.com/medicaid/provider/become-in-network-provider.html.

Adding a New Practitioner to Your Existing Group Practice

Practitioners can go directly to CAQH ProView and complete the credentialing application online through the CAQH ProView secure website. If the CAQH ProView application is already complete, make sure it includes the new practice affiliation information. Once complete, log into the CareFirst Provider Portal (CareFirst Direct) to access the Provider Updates and Attestation Self-Service Tool to add the new practitioner to your existing group. If you need assistance, access this [step-by-step guide](#).

CareFirst CHPMD will receive your updated information electronically and begin the process to add your new practitioner. You will receive written notification of the practitioner's acceptance, provider number, and effective date of participation.

Provider Data Accuracy

Accurate provider data is essential to doing business with CareFirst CHPMD. The information we have for you is displayed in our print and online provider directories. This enables our members, your patients, to find you, determine if you participate with their plan and are accepting new patients and contact you to schedule an appointment at their preferred office location. If the information we have for you is not correct, your patients may not be able to find you and may consider other providers instead.

CareFirst CHPMD conducts regular audits of the directory to ensure the accuracy of provider information. We are also subject to audits by regulatory agencies. If we are unable to confirm the accuracy of your information in our directory, you may be assessed an administrative fee.

As an in-network provider, you need to keep your information updated in two places:

- **CareFirst Directory Data:** CareFirst CHPMD's self-service tool is not integrated with CAQH ProView. Federal law requires all providers to attest and/or update their directory information at least every 90 days with CareFirst CHPMD directly. For more information on how to access and utilize CareFirst CHPMD's self-service tool, review the Keep your Provider Data Accurate page.
- **CAQH ProView Application:** Once you are registered with CAQH, please continue to review and make regular updates any time your credentialing information changes (or at least once each quarter). You will be sent a reminder from CAQH to review, update, and attest your data. For more information about CAQH ProView, visit proview.caqh.org.

In addition, it is important you also keep your data updated in NPPES. NPPES stands for National Plan and Provider Enumeration System and is the database used by NPI number holders and the Centers for Medicare and Medicaid Services (CMS). The NPPES registry is updated regularly; therefore, any changes you make to your CareFirst CHPMD provider directory information should also be reviewed and updated as appropriate in NPPES. For more information, go to NPPES (nppes.cms.hhs.gov/login).

Primary Care Providers (PCPs)

The PCP serves as the entry point for access to healthcare 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 healthcare services covering the full range of benefits.

The PCP is required to:

VII. Provider Services and Responsibilities

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

If a member's PCP is not a Gynecologist, CareFirst CHPMD will allow the member to see a Gynecologist within the **MCO network** without a referral for covered services necessary to provide routine and preventive healthcare 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
- CareFirst CHPMD reduces your reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to CareFirst CHPMD by the Department and CareFirst CHPMD 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 CareFirst CHPMD 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 **410-779-9359** or **800-730-8543** for assistance.

Out-of-Network Providers and Single Case Agreements

Authorizations for out-of-network providers will be reviewed on an individual member basis. If authorization is approved, a request for a Single Case Agreement will be completed for those providers

and facilities that are not rate regulated or will not accept 100% of Medicaid. Upon receipt of the Single Case Agreement request the Provider Contracting department will generate and send this Agreement to the Out-of-Network Provider for signature.

Second Opinions

If a member requests a second opinion, CareFirst CHPMD will provide for a second opinion from a qualified healthcare 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:
CareFirst CHPMD PO Box 915
Owings Mills, MD 21117
Attention: Provider Relations
- 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.

Medical Records Requirements

Providers shall maintain medical records for CareFirst CHPMD members for a minimum of ten (10) years after the medical record is made. Paper medical records shall be located in an office with access restricted to authorized staff; electronic medical records shall be on a computer or other

VII. Provider Services and Responsibilities

device with appropriate security such as passwords or data encryption. Members are to be forwarded copies of their medical records upon written request.

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 CareFirst CHPMD 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 ([hhs.gov/ocr/privacy](https://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 healthcare 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, Healthcare Power of Attorney, and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of healthcare when the individual is incapacitated. The advance directive must be prominently displayed in the adult member's medical record. Requirements include:

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

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

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

VII. Provider Services and Responsibilities

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the healthcare 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 healthcare clearinghouses that transmit healthcare information electronically. The Health Insurance Portability and Accountability Act (HIPAA) has established national standards addressing the security and privacy of health information, as well as standards for electronic healthcare transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit 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 healthcare 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. CareFirst CHPMD 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

CareFirst CHPMD is required to verify that Limited English Proficient (LEP) members have meaningful access to healthcare 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 LEP or reading skills.

CareFirst CHPMD offers telephonic interpretation services and onsite interpretation services for our members. Interpreter services can be arranged by calling CareFirst CHPMD Member Services at 800-730-8543 or 410-779-9359. Interpreter service is at no charge to you or to the member. Telephone assistance for the hearing impaired is provided by Telecommunication Relay Services by calling 711, then provide the member's telephone number.

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.

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 healthcare services, both clinical and administrative, is a process that can be continuously improved. The State of Maryland's quality assurance plan structure and function support efforts to deal efficiently and effectively with any identified quality issue. Daily and through a systematic audit of MCO operations and healthcare 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 CareFirst CHPMD

- 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 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
- An Annual Technical Report that summarizes all Quality Activities

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

In addition to information reported to MDH, CareFirst CHPMD collects additional quality information. Providers may need to provide records for standard medical record audits that

VIII. Quality Assurance Monitoring Plan and Reporting Fraud, Waste, and Abuse

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

CareFirst CHPMD is committed to ensuring that Staff, Subcontractors, and Network Providers perform administrative services and deliver healthcare services in a manner reflecting compliance with statutes, regulations, and contractual obligations. Further, CareFirst CHPMD is committed to fulfilling its duties with honesty, integrity, and high ethical standards as a Maryland Medicaid MCO. CareFirst CHPMD supports the government in its goal to decrease financial loss from false claims and has, as its own goal, the reduction of potential exposure to criminal penalties, civil penalties, civil damages, and administrative actions.

Fraud is knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program or to obtain, by means of false, or fraudulent pretenses, representations, or promises, any of the money, or property owned by, or under the custody, or control of, any health benefit program. Examples of healthcare fraud including but are not limited to:

- The submission of bills or claims for services not received or rendered
- The provider bills for a non-covered service in a manner that makes it a covered service (e.g., routine foot care billed as a more involved form of foot care)
- Reports of (e.g., padded) time units
- Double billing by charging for services reported on another claim
- Submitting bills for an ineligible recipient
- Bills which appear to have been altered
- Unbundling of services included in capitation rate
- Falsification of quality of care and/or treatment outcome data

Waste includes overusing services or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid Program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources. Examples of Abuse include but are not limited to:

- Charging excessively for services or supplies
- Billing for services or supplies that are not medically necessary
- Continuously misusing codes on claims

As a part of its detection efforts, CareFirst CHPMD will perform a minimum level of random reviews in accordance with standards established in collaboration with MDH, in which a selected universe of beneficiaries will be contracted for interviews, and clinical records will be reviewed to identify possible errors or evidence of abuse and/or fraud.

Audits will also be performed following the identification of an area of concern which may suggest possible abusive or fraudulent activity. Such referrals may come from internal and external sources, unusual trends in claims, or other data, provider self-disclosures, and other ongoing monitoring activity.

In working with its providers, CareFirst CHPMD will identify opportunities for improvement and will assess compliance with utilization policies and procedures. When opportunities for improvement are noted, CareFirst CHPMD will work with the specific provider or will incorporate its findings into the implementation of performance measures. If the process identifies issues with program integrity, CareFirst CHPMD will follow up with providers, utilize corrective action plans when indicated, recoup overpayments, or report abusive or fraudulent claims to the Medicaid Fraud and Control Unit.

Reporting Suspected Fraud and Abuse

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

VIII. Quality Assurance Monitoring Plan and Reporting Fraud, Waste, and Abuse

CareFirst CHPMD provides a 24 hour, 7 days a week anonymous hotline to allow any provider or individual to report suspected fraud, and abuse. The hotline number is 410-779-9359 or toll free at 800-336-4522 (TTY: 711). While all callers may remain anonymous, it is CareFirst CHPMD's policy that neither CareFirst CHPMD nor any contracted provider may retaliate against anyone who identifies oneself and reports any incidence or suspicion of Medicaid fraud or abuse.

You can also report provider fraud to the MDH Office of the Inspector General at **410-767-5784** or **866-770-7175**, the Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General, at **410-576-6521 (888-743-0023)** or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **800-HHS-TIPS (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 and abuse in government healthcare 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-\$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
- 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 healthcare 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
- 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 healthcare 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 healthcare program, including programs for children and families accessing CareFirst CHPMD services through Maryland HealthChoice.

VIII. Quality Assurance Monitoring Plan and Reporting Fraud, Waste, and Abuse

Under Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a) (68), CareFirst CHPMD 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 healthcare programs, including programs for children and families accessing CareFirst CHPMD 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
- License suspension or revocation

Remediation may include any or all of the following:

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

Exclusion Lists & Death Master Report

CareFirst CHPMD 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.

CareFirst CHPMD does not participate with or enter into any provider agreement with any individual or entity that has been excluded from participation in Federal healthcare programs, who have a relationship with excluded providers or who have been terminated from Medicaid or any programs by Maryland Department of Health for fraud, waste, or abuse. The provider must agree to assist CareFirst CHPMD 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 healthcare services.

Additional Resources

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

Attachment A: Rare and Expensive Case Management (REM) Program

The 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 CareFirst CHPMD 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 or 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**

Attachment A: Rare and Expensive Case Management (REM) Program

Table of Rare and Expensive Diagnosis

ICD-10	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

Attachment A: Rare and Expensive Case Management (REM) Program

ICD-10	ICD-10 Description	Age Limit
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

Attachment A: Rare and Expensive Case Management (REM) Program

ICD-10	ICD-10 Description	Age Limit
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	Mucopolipidosis 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

Attachment A: Rare and Expensive Case Management (REM) Program

ICD-10	ICD-10 Description	Age Limit
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

Attachment A: Rare and Expensive Case Management (REM) Program

ICD-10	ICD-10 Description	Age Limit
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 with diffuse membranous glomrlneph	0-20
N03.3	Chronic neph syndrome with diffuse mesangial prolif glomrlneph	0-20
N03.4	Chronic neph syndrome with diffuse endocaply prolif glomrlneph	0-20
N03.5	Chronic nephritic syndrome with diffuse mesangiocap glomrlneph	0-20
N03.6	Chronic nephritic syndrome with dense deposit disease	0-20
N03.7	Chronic nephritic syndrome with 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

Attachment A: Rare and Expensive Case Management (REM) Program

ICD-10	ICD-10 Description	Age Limit
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

Attachment A: Rare and Expensive Case Management (REM) Program

ICD-10	ICD-10 Description	Age Limit
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	Congenital 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 extrophy of urinary bladder	0-20
Q75.0	Craniosynostosis	0-20

Attachment A: Rare and Expensive Case Management (REM) Program

ICD-10	ICD-10 Description	Age Limit
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 B

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM			
<input type="checkbox"/> 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: <input type="checkbox"/> Acute/Urgent <input type="checkbox"/> Follow Up <input type="checkbox"/> Health Maintenance	ICD-10 Codes CPT Codes
Provider Name/Title:		Drug Allergy: <input type="checkbox"/> NKDA	
T: Hgt: Rapid Strep P: Wgt: Test: - Hgb: RR: BMI: BGL: BP: U/A: PF: PaO2:	Current Medications:		Immunization review: <input type="checkbox"/> 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:

Provider Signature: _____

PCP F/U Required: <input type="checkbox"/> Yes <input type="checkbox"/> No
--

Attachment C

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	alleganyhealthdept.com
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	aahealth.org
Baltimore City	410-396-4398	410-396-7633	410-640-5000	health.baltimorecity.gov
Baltimore County	410-887-2243	410-887-2828	410-887-8741	baltimorecountymd.gov
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	calverthealth.org
Caroline	410-479-8000	410-479-8014	410-479-8189	carolinehd.org
Carroll	410-876-2152	410-876-4813	410-876-4941	cchd.maryland.gov
Cecil	410-996-5550	410-996-5171	410-996-5130	cecilcountyhealth.org
Charles	301-609-6900	301-609-6923	301-609-6760	charlescountyhealth.org
Dorchester	410-228-3223	410-901-2426	410-901-8167	dorchesterhealth.org
Frederick	301-600-1029	301-600-1725	301-600-3124	health.frederickcountymd.gov
Garrett	301-334-7777	301-334-7727	301-334-7771	garretthealth.org
Harford	410-838-1500	410-638-1671	410-942-7999	harfordcountyhealth.com
Howard	410-313-6300	877-312-6571	410-313-7323	howardcountymd.gov/departments/health
Kent	410-778-1350	410-778-7025	410-778-7035	kenthd.org
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1635	montgomerycountymd.gov/hhs
Prince George's	301-883-7879	301-856-9555	301-856-9550	princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4456	qahealth.org
St. Mary's	301-475-4330	301-475-4296	301-475-4330	smchd.org
Somerset	443-523-1700	443-523-1722	443-523-1758	somersethealth.org
Talbot	410-819-5600	410-819-5609	410-819-5600	health.maryland.gov/talbotcounty/Pages/home.aspx
Washington	240-313-3200	240-313-3264	240-313-3290	health.maryland.gov/washhealth/Pages/home.aspx
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	wicomicohealth.org
Worcester	410-632-1100	410-632-0092	410-629-0614	worcesterhealth.org

Attachment D

HealthChoice Local Health Services Request Form

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

MCO:	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) _____ # Face to Face _____	<input type="checkbox"/> Unable to Locate <input type="checkbox"/> Contact Date: / / <input type="checkbox"/> Advised <input type="checkbox"/> 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 _____	<input type="checkbox"/> No Action (returned) Reason for return: _____ Disposition: <input type="checkbox"/> Contact Complete: Date: / / <input type="checkbox"/> Unable to Locate: Date: / / <input type="checkbox"/> Referred to: Date: / /
Contact Person: Contact Phone:	
Comments:	

Attachment E

Maryland Prenatal Risk Assessment

Refer to instructions on back before starting.

Maryland Prenatal Risk Assessment- MDH 4850

(Refer to the Instructions at the bottom of this document before completing this form)

Provider Demographic Information:

Date of Initial Prenatal Visit/ Form Completed: ____/____/____
 Provider NPI#: _____ Site NPI# _____
 Provider Name: _____ Provider Phone Number: ____-____-____

Patient Demographic Information:

Patient Last Name: _____ First Name: _____ Middle I: _____
 DOB: ____/____/____ Preferred Pronouns: _____
 Social Security Number: ____-____-____ Medical Assistance Number (MA): _____
 Current Address: Street _____ County _____ State _____ ZipCode _____
 Best Contact Phone Number: ____-____-____ Email: _____
 Emergency Contact Name: _____ Contact Phone Number: ____-____-____
 Communication Barrier: Yes ____ (Requires an Interpreter Y/N) No ____ Primary Language _____

Insurance Status (at time of prenatal visit):

Uninsured: Y ____ N ____	FFS: Y ____ N ____	Applied for Maryland MA: Y ____ N ____ Date: ____/____/____
Maryland Medicaid: Y ____ N ____		MCO: _____

Demographics:

<u>Biologic Sex</u>	Male ____ Female ____	Other: _____	
<u>Gender Identity</u>	Cisgender: Male ____ Female ____	Other: (Patient's own definition) _____	
<u>Race (check all that apply)</u>	Black or African American ____	Asian ____	American Native ____
	Hispanic ____	Native Hawaiian/Pacific Islander _____	Alaska Native ____
	Non Hispanic White	Multiracial	Unknown
<u>Educational Level:</u>	Highest Grade Completed ____	Currently in School: Yes ____ No ____	GED: Yes ____ No ____
<u>Marital Status:</u>	Married ____	Unmarried ____	Unknown ____
	Separated ____	Divorced ____	

Obstetric History Gravida ____ Para ____:

#Full Term Births		#Preterm Births		#Ectopic Pregnancies	
#Spontaneous Abortions		#Therapeutic Abortions		#Living Children	

Entry to Prenatal Care:

Date of Initial OB visit	____/____/____	Trimester of 1st Prenatal visit	____ 1st ____ 2nd ____ 3rd
LMP	____/____/____	EDC	____/____/____

Attachment E

Risk Factor Assessment:

Psychosocial Risks (Check all that apply)

Mental/Behavioral Health ¹	Overwhelming Anxiety/Stress: Y ___ N ___ Poor Coping Skills: Y ___ N ___ Depression: (Active Diagnosis): Y ___ N ___ Past Hx: Y ___ N ___ Partner Dissatisfaction: Y ___ N ___ Intimate Partner/Family Violence/Abuse: Y ___ N ___ Developmental Disability: Y ___ N ___
Behavioral Health Admissions ²	Recent Psychiatric Inpatient Admission within <1 year: Y ___ N ___ Admission Diagnosis: _____
Substance Misuse ²	Drugs and/or Opioid Misuse/Addiction: Y ___ N ___ Drug: _____ Currently in SUD treatment: Methadone _____ Subutex _____ Recent SUD related Inpatient Admission. within <1 year: Y ___ N ___ Exchanging sex for drugs: Y ___ N ___ Nicotine/Tobacco/Vaping use: Y ___ N ___ Amount: _____ Alcohol: Y ___ N ___ Amount ___/day
Financial Insecurity ³	Currently Unemployed: Y ___ N ___ Temporary Assistance for Needy Families (TANF) eligibility: Y ___ N ___
Social Support/Network ⁴	Identified lack of Friends/Family Social Support Network: Y ___ N ___ Housing Insecurity/Homelessness: Y ___ N ___ Lack of Transportation: Y ___ N ___ Child Care Issues: Y ___ N ___ Recent incarceration/Partner currently incarcerated: Y ___ N ___
Nutrition	Food Insecurity/Poor Nutrition: Y ___ N ___
Exercise//Self Care	Lack of regular exercise (30min/day for at least 3x/wk): Y ___ N ___

Medical Risks (Check all that apply)

Maternal Age	Age< or = 16 _____ Age> or = 35 _____
Maternal BMI	BMI<18.5 _____ or BMI>30 _____
Sexually Transmitted Infection - STI. (GC/Chlamydia/HIV/Hep B/C or Syphilis)	Current/Recently Treated STI: STI Name: _____ STI screening (including Syphilis) completed for current Pregnancy: Y ___ N ___ Past STI Hx: (Syphilis) _____ (Herpes) _____
Chronic Disease	Asthma: Y ___ N ___ Inhaler Rx: Y ___ N ___ Diabetes Y ___ N ___; If YES then Treatment Medication: _____ Chronic HTN/Heart Disease: Y ___ N ___ Sickle Cell Disease: Y ___ N ___ Sickle Cell Trait: Y ___ N ___ Anemia - HCT<33 or HGB <11: Y ___ No ___ Lab Result _____ Autoimmune Disorder: Y ___ N ___ If yes please name: _____ H/O - Thrombophilias/DVT: _____ If yes please describe. _____

Dental Care	Last Dental visit >1 year. Y ___ N ___
-------------	--

Pregnancy Risk Factors (Check all that apply)

Identified obstetric risks	Patient's First Pregnancy: Yes ___ No ___ Covid Vaccinated: Yes ___ No ___ Covid Booster Current: Yes ___ No ___ Short Interval Pregnancy <9 Months from last birth: Yes ___ No ___ Late Entry into Care >14 week: Y ___ N ___ Previous H/O Preterm Labor/Birth: Y ___ N ___ H/O Previous Gestational Diabetes: Y ___ N ___ Current multiple gestation pregnancy: Y ___ N ___ H/O previous LBW Baby: Y ___ N ___ H/O previous Fetal Death In Utero >20 weeks: Y ___ N ___ Previous Pregnancy affected with Preeclampsia/Eclampsia/HELLP Syndrome: Y ___ N ___ H/O Cervical Incompetence: Y ___ N ___ H/O Previous infant affected with congenital defect: Y ___ N ___ Define: _____
----------------------------	---

DEFINITIONS (To help complete Risk Assessment)

¹ Mental/Behavioral Health	Concern for the need of BH Services.
¹ Intimate Partner/Family Violence/Abuse	Physical, psychological abuse or violence within the patient's environment.
¹ Exposure to long-term stress	Partner-related, financial, personal, emotional.
² Substance Misuse	<ul style="list-style-type: none"> Concern for use of illegal substances within the past 6 months. At "risk-drinker" as determined by a screening tool such as T-ACE, CAGE, or AUDIT.
³ Financial Insecurity	Example: Unemployed > 3months. Involved in exchanging sex for drugs.
⁴ Lack of social/emotional support	Absence of support system i.e. family/friends. Feeling isolated.
Family History/Genetic risk.	At risk for a genetic or hereditary disorder. Known genetic carrier. H/O congenital anomalies.
Communication barrier	In need of an interpreter.
Dental Care	Last Dental Visit > 1year.
Prior Preterm birth	H/O of preterm birth (prior to the 37th gestational age).
Prior LBW birth	Low birth weight birth (under 2,500 grams).

Attachment E

Maryland Prenatal Risk Assessment Form (Instructions for use)

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 nurses, community health and outreach workers and may include education about Medicaid benefits, reinforcement of the medical plan of care, resource linkage and other related services.

Instructions: On the initial visit the provider/staff will complete the demographic and assessment sections for pregnant

Fax the MPRA to the local health department in the woman's county of residence See list of ACCU below)

Mailing Address (client resides)	Phone Number
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-55107 Fax: 301-777-2401
Anne Arundel County ACCU 3 Harry S. Truman Parkway, HD8 Annapolis, MD 21401	410-222-7177 Fax: 410-222-4150
Baltimore City ACCU Healthcare Access Maryland 1 N. Charles St., #900 Baltimore, MD 21201	410-410-949-2357 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, Prince Frederick, MD 20678	410-535-5400 Fax: 410-535-1955
Caroline County ACCU 403 S. 7th St. Denton, MD 21629	410-479-8189 Fax: 410-479-4871
Carroll County ACCU 290 S. Center St, Westminster, MD 21158-0845	410-876-4941 Fax: 410-876-4949
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5130 Fax: 410-996-0072
Charles County ACCU 4545 Crain Highway White Plains, MD 20695	301-609-6760 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-901-8167Fax: 410-228-8976
Frederick County ACCU 350 Montevue Lane Frederick, MD 21702	301-600-3131 Fax: 301-600-3372
Garrett County ACCU 1025 Memorial Drive	301-334-7695 Fax: 301-334-7771

women enrolled in Medicaid at registration and those applying for Medicaid.

- 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 the 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, punch holes or staple forms. **Fax the MPRA to the local health department in the client's county of residence.** To reorder forms call the local ACCU.

Oakland, MD 21550	
Harford County ACCU 2015 Pulaski Highway, #E, Havre De Grace, MD 21078	410-942-7909 Fax: 443-502-8975
Howard County ACCU 8930 Stanford Blvd., . Columbia, MD 21045	410-313-7567 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7035 Fax: 410-778-7019
Montgomery County ACCU 1401 Rockville Pike, #2400 Rockville, MD 20852	240-777-1648 Fax: 240-777-1604
Prince George's County ACCU 9314 Piscataway Rd., Clinton, MD 20735	301-301-856-9403Fax: 301-856-9628
Queen Anne's County ACCU 206 N. Commerce Street Centreville, MD 21617	443-262-4456 Fax: 443-262-9357
St Mary's County ACCU 21580 Peabody St. Leonardtown, MD 20650	301-475-6776 Fax: 301-309-4117
Somerset County ACCU 8928 Sign Post Rd., Westover, MD 21871	443-523-1758 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	240-313-3464 Fax: 240-313-3222
Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6987

Attachment F

Prenatal/Postpartum Programs

Baby Steps is the OB Wellness Program offered by CareFirst CHPMD. To ensure the healthiest pregnancy possible, all pregnant members are enrolled into Baby Steps. As soon as a member is enrolled into BabySteps they will receive an education package that includes:

- Free meal service for members who are 20–28 weeks pregnant
- A welcome letter
- Contact information for a dedicated OB Case Manager
- Self-care information including a guide to track appointments and information about their pregnancy
- Information on our text program that delivers prenatal health and nutrition information
- Brochures on how tobacco, alcohol, and drugs affect pregnancy, nutrition during pregnancy, and car seat safety for parents and baby

CareFirst CHPMD provides:

- Prenatal visits with no copays
- Free breast pump
- Prenatal vitamins
- Nutrition counseling session
- Smoking cessation assistance
- OTC medications and supplies
- Home health services when medically necessary

During the pregnancy the OB Case Manager will:

- Contact the member periodically to make sure they are getting the care they need
- Send additional information on how to know when they are in labor, pain relief during labor and breastfeeding
- Discuss birth control options for after delivery
- Address any concerns or questions members might have, as well as connect members to community resources available

After delivery the OB Case Manager will send a postpartum education package that includes:

- A congratulations letter
- Baby care information including safe sleep, managing stress, and a newborn immunization record booklet
- Wellness visit and vaccination schedule for baby
- Brochures about postpartum depression, domestic violence, exercise and health after pregnancy

For more information about Baby Steps or to contact an OB Case Manager call 410-779-9359 or 800-730-8543 or visit the CareFirst CHPMD website: [carefirst.com/medicaid/members/pregnancy-benefits.html](https://www.carefirst.com/medicaid/members/pregnancy-benefits.html).

Attachment G

Case Management Services

CareFirst CHPMD offers case management to members who have had a critical medical event, been diagnosed with a chronic illness and have multiple illnesses or complications.

A dedicated case management team will work with members and providers to help members get the services, resources, and one-one coaching needed to better take care of their health. Case management services are voluntary and are provided at no cost to the member. Members identified with certain needs may be automatically enrolled, but are under no obligation to participate in these programs.

For more information about Case Management Services, to refer a member to case management or to speak with a Case Manager call 410-779-9359 or 800-730-8543.

Attachment H

Disease Management

CareFirst CHPMD utilizes a Population Health Management structure to offer disease management to members with one of the following chronic conditions:

- Diabetes
- Hypertension
- Asthma
- CHF (Congestive Heart Failure)
- COPD (Chronic Obstructive Pulmonary Disease) and/or
- Hypercholesterolemia

A team will work with members and providers to educate about chronic conditions, as well as implement healthy behaviors to live with one or more chronic diseases like medication adherence, nutrition plans, avoiding at risk behaviors, and recognizing symptoms of problems with conditions. The team offers support to members for regular appointments for wellness checks, immunizations, lab work, and other supportive healthcare interventions.

For more information about Disease Management, to refer a member to disease management or to speak with Population Health Management team member call 410-779-9359 or 800-730-8543.

Attachment I

Telemedicine, and Remote Patient Monitoring

CareFirst CHPMD offers Telemedicine and/or Remote Patient Monitoring to members who consent to participate in Case Management Services for high-risk members and who meet the eligibility criteria pursuant to COMAR 10.09.96 and is at risk for avoidable hospital utilization due to poorly controlled:

- Diabetes
- CHF (Congestive Heart Failure) and/or
- COPD (Chronic Obstructive Pulmonary Disease)

Participants must also meet the following criteria:

- Remote patient monitoring may reduce the risk of preventable hospital utilization and promote improvement in the control of one of the above chronic conditions
- Have internet connections necessary to host the equipment in the home
- While eligible with CareFirst CHPMD have had:
 - Two (2) or more hospital admissions within the prior 12 months with the same qualifying condition as the primary diagnosis, or
 - Two (2) or more emergency department visits within the prior 12 months with the same qualifying condition as the primary diagnosis, or
 - One (1) hospital admission and one (1) separate emergency department visit within the prior 12 months with the same qualifying condition as the primary diagnosis.

Attachment J

Additional Services Offered By MCO

Benefit	What it is	Who can get this benefit	Limitations
Prenatal Benefits	CareFirst CHPMD will provide one (1) nutrition consultation appointment per pregnancy.	Pregnant members	
Prenatal Benefit (Bright Beginnings Benefit)	CareFirst CHPMD will provide one (1) \$125 gift card for attending a childbirth class, breastfeeding class, or infant care class. After completing one of the classes listed above, please call member services 410-779-9369 or 800-730-8530 (TTY:711) to confirm your attendance, date, location, and provider	Pregnant members	
After Pregnancy Benefits (Baby Steps Benefit)	CareFirst CHPMD will provide one (1) \$125 gift card for new parent to use for baby safety items, such as a Pack-n-play, car seat, sleep clothes, and more.	Post-pregnancy members	Gift card will be provided to members following delivery.
Adult Vision	The mandatory HealthChoice benefit allows for adults to receive a vision exam every two years. CareFirst CHPMD will provide one pair of glasses or contact lenses every two years to all adult members in the event the exam outlines the needed for glasses.	Adults 21 and older	\$150 limit for glasses or contact lenses. Members can contact Superior Vision at 888-486-1230. Providers should use 877-235-5317.
Pediatric Vision	The mandatory HealthChoice benefit allows for those under 21 to receive a vision exam every year. CareFirst CHPMD will provide glasses and contact lenses if there is a medical reason why glasses will not work.	Members under 21	Contact lenses only if medically necessary.
Over the Counter Medications and Supplies (OTC)	With a prescription from a provider, members can receive OTC items through the CareFirst CHPMD Formulary.	All members	
Home Delivered Meals Post-Discharge from a Hospital Stay	CareFirst CHPMD will provide members with up to 18 nutritious meals to eligible members recovering from an inpatient stay in a hospital who have no support at home upon discharge.	All members	CHPMD Care Manager must verify the inpatient stay.
Transportation	CareFirst CHPMD members get 6 free one-way rides for all non-emergency medical needs. Visit carefirst.member.saferidehealth.com or call 833-509-0250.	All members	6 one-way rides during one benefit year



HealthChoice is a Program of the Maryland Department of Health.

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