Priority Partners MCO
Provider Manual

Sponsored by Johns Hopkins HealthCare LLC and
The Maryland Community Health Systems

2010
Introduction to the Provider Manual

HealthChoice is Maryland’s Medicaid managed care program. Overseen by the Maryland Department of Health and Mental Hygiene (DHMH), the HealthChoice program serves over 500,000 individuals. These individuals are enrolled in one of the participating managed care organizations (MCOs). Each MCO has policies and procedures that providers who deliver services to recipients must adhere to. Any questions a provider has about the policies of individual MCOs should be addressed by the provider information supplied by the MCO they participate in.

While each HealthChoice MCO has its own policies and procedures, many program elements apply to all providers, regardless of the MCO. The purpose of this manual is to explain those elements and be a useful reference for providers who participate in the HealthChoice program. The manual is divided into seven sections:

Section I - General Information. This section provides general descriptive information on the HealthChoice program including, but not limited to, program eligibility, MCO reimbursement policies, continuity of care and transportation.

Section II - Provider Responsibilities. This section discusses expectations of all providers, regardless of MCO affiliation.

Section III - HealthChoice Benefits and Services. This section provides a listing of the benefits that are and are not the responsibility of all MCOs that participate in HealthChoice. This section briefly outlines some of the optional benefits that Priority Partners may provide. This section also identifies benefit limitations and services that are not the responsibility of Priority Partners.

Section IV - Specialty Mental Health Services. Individuals eligible for the HealthChoice program who are receiving specialty mental health services may receive some or all of their services outside of Priority Partners network. This section details the services.

Section V - Rare and Expensive Case Management (REM). Members with certain diagnoses may disenroll from Priority Partners and receive their services through the REM program. This section details the REM program.

Section VI - DHMH Quality Improvement Program and MCO Oversight Activities. DHMH conducts numerous quality improvement activities for the HealthChoice program. This section reviews DHMH’s quality improvement activities. These activities are separate from quality improvement activities that Priority Partners may engage in.

Section VII –Corrective Managed Care. This section discusses the steps that should be taken if a member is determined to have abused MCO pharmacy benefits.

Section VIII – Additional Priority Partners Information.
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Section I
GENERAL INFORMATION
THE MARYLAND HEALTHCHOICE PROGRAM

HealthChoice is Maryland’s Medicaid Managed Care program. Almost three-quarters of the Medicaid population and the Maryland Children’s Health Program (MCHP) are enrolled in this program. The HealthChoice Program’s philosophy is based on providing quality cost-effective and accessible health care that is patient-focused.

HEALTHCHOICE ELIGIBILITY

All individuals qualifying for Maryland Medical Assistance or MCHP are enrolled in the HealthChoice Program, except for the following categories:

- Individuals who receive Medicare;
- Individuals age 65 or over;
- Individuals who are eligible for Medicaid under spend down;
- Medicaid recipients who have been or are expected to be continuously institutionalized for more than 30 successive days in a long term care facility or in an institution for mental disease (IMD);
- Individuals institutionalized in an intermediate care facility for mentally retarded persons (ICF-MR);
- Recipients enrolled in the Model Waiver;
- Recipients who receive limited coverage, such as women who receive family planning; services through the Family Planning Waiver, Primary Adult Care Program or Employed Individuals with Disabilities Program;
- Inmates of public institutions, including a State operated institution or facility;
- A child receiving adoption subsidy who is covered under the parent’s private insurance;
- A child under State supervision receiving adoption subsidy who lives outside of the State; or
- A child who is in an out-of-State placement.

All Medicaid recipients who are eligible for the HealthChoice Program, without exception, will be enrolled in an MCO or in the Rare and Expensive Case Management Program (REM). The REM program is discussed in detail in Section V.
Medicaid-eligible individuals who are not eligible for HealthChoice will continue to receive services in the Medicaid fee-for-service system.

**PROVIDER REIMBURSEMENT**

Payment is in accordance with your provider contract with Priority Partners (or with their management groups that contract on your behalf with Priority Partners). 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. You must verify through the Eligibility Verification System (EVS) that recipients are assigned to Priority Partners before rendering services.

Reimbursement for hospitals and other applicable provider sites will be in accordance with Health Services Cost Review Commission (HSCRC) rates.

Priority Partners is not responsible for payment of any remaining days of a hospital admission that began prior to a Medicaid recipient’s enrollment in Priority Partners. We are however, responsible for reimbursement to providers for professional services rendered during the remaining days of the admission.

**Self-Referred and Emergency Services**

Priority Partners will reimburse out-of-plan providers for the following services:

- Emergency services provided in a hospital emergency facility;
- Family planning services except sterilizations;
- 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. A school based health center reporting form can be found in Section VI;
- 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;
- Annual Diagnostic and Evaluation services for recipients with HIV/AIDS;
- Renal dialysis provided at a Medicare-certified facility;
• The initial examination of a newborn by an on-call hospital physician when we do not provide for the service prior to the baby’s discharge; and

• An initial assessment for substance abuse.

• Substance abuse services such as individual and group counseling, detoxification and inpatient care when provided by an ADAA certified provider and ASAM criteria is met.

Self-Referred Services for Children with Special Health Care Needs

Children with special health care needs may self-refer to providers outside of the Priority Partners network under certain conditions. Self-referral for children with special needs is intended to insure continuity of care and appropriate plans of care. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child’s special health care needs is diagnosed before or after the child’s initial enrollment in Priority Partners. 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 Priority Partners and we approve the services as medically necessary.

• **Established Member:** A child who is already enrolled in Priority Partners when diagnosed as having a special health care need requiring a plan of care that includes specific types of services may request a specific out-of-network provider. We are obliged to grant the member’s request unless we have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same services and service modalities.

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

**PRIMARY CARE PROVIDER (PCP) CONTRACT TERMINATIONS**

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

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

CONTINUITY OF CARE

As part of the HealthChoice Program design, we are responsible for providing ongoing treatments and patient care to new recipients until an initial evaluation is completed and we develop a new plan of care.

The following steps are to be taken to ensure that members continue to receive necessary health services at the time of enrollment into Priority Partners:

• Appropriate service referrals to specialty care providers are to be provided in a timely manner.

• Authorization for ongoing specialty services will not be delayed while members await their initial PCP visit and comprehensive assessment. Services comparable to those that the member was receiving upon enrollment into Priority Partners are to be continued during this transition period.

• If, after the member receives a comprehensive assessment, we determine that a reduction in or termination of services is warranted, we will notify the recipient of this change at least 10 days before it is implemented. This notification will tell the member that he/she has the right to formally appeal to the MCO or to the Department by calling the MCO or the Enrollee Help Line at 800-284-4510. In addition, the notice will explain that if the member files an appeal within ten days of our notification, and requests to continue receiving the services, then we will continue to provide these services until the appeal is resolved. You will receive a copy of this notification.

SPECIALTY REFERRALS

• We will maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits as required by COMAR 10.09.66 and 10.09.67.

• If a specialty provider cannot be identified contact us at 800-654-9728 or the Provider Hotline at 800-766-8692 for assistance.
TRANSPORTATION

You may contact the Local Health Department (LHD) to assist members in accessing non-emergency transportation services. Priority Partners will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD.

We will provide non-emergency transportation necessary for our members to access a covered service if we choose to provide the service at a location that is outside of the closest county (or Baltimore City) in which the service is available.
Section II
PROVIDER RESPONSIBILITIES
CONFIDENTIALITY
Providers are expected to maintain policies and procedures within their offices to prevent the unauthorized or inadvertent disclosure of confidential information according to the terms of the Participating Provider Agreement and Payor Addendum.

REPORTING COMMUNICABLE DISEASE

You must ensure that all cases of reportable communicable disease that are detected or suspected in a member by either a clinician or a laboratory are reported to the LHD as required by Health - General Article, 18-201 to 18-216, Annotated Code of Maryland and COMAR 10.06.01 Communicable Diseases.

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

- The provider report must identify the disease or suspected disease and demographics on the member including the name, age, race, sex and address of residence, hospitalization, date of death, etc. on a form provided by the Department (DHMH-1140) 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 DHMH.

Other Reportable Diseases and Conditions

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

- An outbreak of a disease of known or unknown etiology that may be a danger to the public health is reportable immediately by telephone.

Reportable Communicable Diseases - Laboratory Providers

Providers of laboratory services must report positive laboratory results as directed by Health - General Article 18-205, Annotated Code of Maryland.
Laboratories that perform mycobacteriology services located within Maryland, must report all positive findings to the Health Officer of the jurisdiction in which the laboratory is located. For out-of-state laboratories licensed in Maryland and performing tests on specimens from Maryland, the laboratory may report to the Health Officer of the county of residence of the patient or to The Maryland DHMH, Division of Tuberculosis Control within 48 hours by telephone 410-767-6698 or fax 410-669-4215.

We cooperate with LHDs in investigations and control measures for communicable diseases and outbreaks. Following is a list of reportable communicable diseases:

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<td>Anaplasmosis</td>
<td>Mumps (infectious parotitis)</td>
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<td>Animal bites</td>
<td>Mycobacteriosis, other than tuberculosis and leprosy</td>
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<td>Anthrax</td>
<td>Novel influenza A virus infection</td>
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<td>Arboviral infections</td>
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<td>Botulism</td>
<td>Pesticide related illness</td>
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<td>Brucellosis</td>
<td>Plague</td>
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<td>Poliomyelitis</td>
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<td>Chlamydia infection</td>
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<td>Coccidiodomycosis</td>
<td>Rabies</td>
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<td>Hemolytic uremic syndrome, post-diarrheal</td>
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<td>Measles (rubeola)</td>
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<td>Meningitis, infectious</td>
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<td>Meningococcal invasive disease</td>
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**APPONITMENT SCHEDULING AND OUTREACH REQUIREMENTS**

In order to ensure that HealthChoice members have every opportunity to access needed health related services, as specified under COMAR 10.09.66, PCPs must develop collaborative relationships with the following entities to bring members into care:

- Priority Partners;
- Specialty care providers;
- The Administrative Care Coordination Units (ACCU) at the LHD;
- DHMH Provider Hotline staff as needed.

We will, before referring an adult member to the local health department, make documented attempts to ensure that follow-up appointments are scheduled in accordance with the member’s treatment plan by attempting a variety of contact methods, which may include written correspondence, telephone contact and face-to-face.

Prior to any appointment for a HealthChoice recipient you must call EVS at 866-710-1447 to verify recipient eligibility and MCO enrollment. This procedure will assist in ensuring payment for services.
**Initial Health Appointment for HealthChoice Members**

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

- You determine that no immediate initial appointment is necessary because the member already has an established relationship with you.

- For children under 21, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) periodicity schedule requires a visit in a shorter timeframe. For example, new members up to two years of age must have a well child visit within 30 days of enrollment unless the child already has an established relationship with a provider and is not due for a well child visit.

- For pregnant and post-partum women who have not started to receive care, the initial health visit must be scheduled and the women seen within 10 days of a request.

- As part of the enrollment process the State conducts a Health Risk Assessment (HRA) and screens each HealthChoice recipient for conditions requiring expedited intervention by providers. HealthChoice recipients who screen positive must be seen for their initial health visit within 15 days of Priority Partners receipt of the completed HRA.

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 physical status, behavior of the member, or laboratory findings indicate possible substance abuse, you are to perform a substance abuse screening using approved Substance Abuse and Mental Health Services Administration (SAMSA) screening instruments that are appropriate for the age of the member.

**SERVICES FOR CHILDREN**

For children younger than 21 years old, we shall assign the member to a PCP who is certified by the EPSDT Program, unless the member or member’s parent, guardian, or caretaker, as appropriate, specifically requests assignment to a PCP who is not EPSDT-certified. In this case the non-EPSDT provider is responsible for ensuring that the child receives well child care according to the EPSDT schedule.
Wellness Services for Children Under 21 Years

Providers shall refer children for specialty care as appropriate. This includes:

- Making a specialty referral when a child is identified as being at risk of a developmental delay by the developmental screen required by EPSDT; is experiencing a delay of 25% or more in any developmental area as measured by appropriate diagnostic instruments and procedures; is manifesting atypical development or behavior; or has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay; and

- Immediately referring any child thought to have been abused physically, mentally, or sexually to a specialist who is able to make that determination.

You are to follow the rules of the Maryland Healthy Kids Program to fulfill the requirements under Title XIX of the Social Security Act for providing children under 21 with EPSDT services. The Program requires you to:

- Notify members of their due dates for wellness services and immunizations.

- Schedule and provide preventive health services according to the State’s EPSDT Periodicity Schedule and Screening Manual.

- Refer infants and children under age 5 and pregnant women 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 Vaccination For Children (VFC) Program. Many of the routine childhood immunizations are furnished under the VFC Program. The VFC Program provides free vaccines for health care providers who participate in the VFC Program. When new vaccines are approved by the Food and Drug Administration, the VFC Program is not obligated to make the vaccine available to VFC providers. Therefore, under the HealthChoice formulary requirement (COMAR 10.09.67.04D(3)), we will pay for new vaccines that are not yet available through the VFC.

Members under age 21 are eligible for a wider range of services under EPSDT than the adult population. PCPs are responsible for understanding these expanded services (see Section III Benefits) so that appropriate referrals are made for services that prevent, treat, or ameliorate physical, mental or developmental problems or conditions.

Appointments must be scheduled at an appropriate time interval for any member who has an identified need for follow-up treatment as the result of a diagnosed condition.
Healthy Kids (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.

- Notify our case management unit at 888-309-4576 for assistance with outreach as defined in the Provider Agreement.

- 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 making a referral to the ACCU of the LHD. Use the Local Health Services request form (See www.dhmh.state.md.us/mma/LHS/index).

- After referring to the ACCU, work collaboratively with the ACCU and Priority Partners to bring the child into care. This collaborative effort will continue until the child complies with the EPSDT periodicity schedule or receives appropriate follow-up care.

SPECIAL NEEDS POPULATIONS

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

- Pregnant and postpartum women
- Children with special health care needs
- Individuals with HIV/AIDS
- Individuals with a physical disability
- Individuals with a developmental disability
- Individuals who are homeless
- Individuals with a need for substance abuse treatment
- Children in State-supervised care
Services Every Special Needs Population Receives

In general, 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 recipient or the PCP, a case manager trained as a nurse or a social worker will be assigned to the recipient. The case manager will work with the member and the PCP to plan the treatment and services needed. The case manager will not only help plan the care, but will help keep track of the health care services the member receives during the year and will serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.

- The PCP and our case managers, when required, coordinate referrals for needed specialty care. This includes specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. PCPs should follow the referral protocols established by us for sending HealthChoice members to specialty care networks.

- We have a Special Needs Coordinator on staff to focus on the concerns and issues of special needs populations. The Special Needs Coordinator helps members find information about their condition or suggests places in their area where they may receive community services and/or referrals.

- All of our 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 may be referred to the local health department for specific outreach efforts, according to the process described below.

If the PCP or specialist finds that a member continues to miss appointments, Priority Partners must be informed. We will attempt to contact the member by mail, telephone or by a home
visit. If we are unsuccessful in these outreach attempts, we will notify the local health department in the jurisdiction where the member lives.

Within 10 days of either the third consecutive missed appointment, or you becoming aware of the patient’s repeated non-compliance with a regimen of care, whichever occurs first, you should make a written referral to the LHD ACCU using the Local Health Services Request Form (See www.dhmh.state.md.us/mma/LHS/index). The ACCU will assist in locating and contacting the member for the purpose of encouraging them to seek care. After referral to the ACCU, Priority Partners and our providers will work collaboratively with the ACCU to bring the member into care.

Services for Pregnant and Post Partum Women

Priority Partners and our providers are responsible for providing pregnancy-related services, which include:

- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment form
- Comprehensive prenatal, perinatal, and postpartum care (including high-risk specialty care);
- Development of an individualized plan of care, which is based upon the risk assessment and is modified during the course of care if needed;
- Case management services;
- Prenatal and postpartum counseling and education;
- Basic nutritional education;
- Special substance abuse treatment including access to treatment within 24-hours of request and intensive outpatient programs that allow for children to accompany their mother;
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant women;
- Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers;
- Post partum home visits;
- Referral to the ACCU.
The PCP, OB/GYN and Priority Partners are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcome. Examples of appropriate referrals include the Women Infants and Children special supplemental nutritional program (WIC) and the local health departments’ ACCU. In connection with such referrals, necessary medical information will be supplied to the program for the purpose of making eligibility determinations.

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

You must:

- Schedule prenatal appointments in a manner consistent with the ACOG guidelines.
- Provide the initial health visit within 10 days of the request.
- Complete the Maryland Prenatal Risk Assessment form – DHMH 4850 (Sample form page 25) for each pregnant member and submit it to the Local Health Department in the jurisdiction in which the member lives within 10 days of the initial visit.
- For pregnant members under the age of 21, refer them to their PCP to have their EPSDT screening services provided.
- Reschedule appointments within 10 days for members who miss prenatal appointments.
- Refer to the WIC Program.
- Refer pregnant and postpartum members who are substance abusers for appropriate substance abuse assessments and treatment services.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- Instruct pregnant member to notify Priority Partners of her pregnancy and her expected date of delivery after her initial prenatal visit.
- Instruct the pregnant member to contact Priority Partners for assistance in choosing a PCP for the newborn prior to her eighth month of pregnancy.
- Document the pregnant member’s choice of pediatric provider in the medical record.
- Advise pregnant member that she should be prepared to name the newborn at birth. This is required for the hospital to complete the “Hospital Report of Newborns”, DHMH 1184 and get the newborn enrolled in HealthChoice.
### MARYLAND PREGNATAL RISK ASSESSMENT

(For hand written information in capital letters, and refer to instructions on back before starting.)

**Provider Name:**

**MA Provider #:**

**Provider Phone Number:**

#### LAST NAME:  
**FIRST NAME:**  
**ME:**

#### HOUSE NUMBER:  
**STREET NAME:**

#### CITY:  
**COUNTY:** If patient lives in Baltimore City, leave blank  
**STATE:**

#### HOME PHONE NUMBER:  
**WORK PHONE NUMBER:**

#### SOCIAL SECURITY NUMBER:  
**DATE OF BIRTH:**

#### RACE:  
- [ ] African American  
- [ ] Asian/Pacific Islander  
- [ ] Native American  
- [ ] Biracial/Multiracial  
- [ ] Unknown  
**HISPANIC:**  
- [ ] Yes  
- [ ] No

#### MARITAL STATUS:  
- [ ] Married  
- [ ] Unmarried  
- [ ] Unknown

#### Date of this prenatal visit:

- [ ] Transferred from other source of prenatal care

#### Other source of prenatal care:

#### Trimester of registration for prenatal care:

- [ ] 1st  
- [ ] 2nd  
- [ ] 3rd

#### INITIAL LOC:

#### PREVIOUS PREGNANCIES:

- [ ] Full-term live births
- [ ] Ectopic pregnancies
- [ ] Pre-term live births
- [ ] Children now living
- [ ] Spontaneous abortions
- [ ] Prior LBW births
- [ ] Therapeutic abortions

#### PSYCHOSOCIAL RISKS:

- [ ] No
- [ ] Yes

- [ ] Age 15 or under
- [ ] Less than 12th grade education or no GED
- [ ] Less than 1 year since last delivery
- [ ] Abuse/Violence
- [ ] Recent incarceration
- [ ] Housing/Environmental concerns
- [ ] Lack of social/emotional support
- [ ] Disability (mental/physical/developmental)
- [ ] Language barrier (specify language in comments box)
- [ ] Late registration (more than 20 weeks gestation)
- [ ] Missed appointments/Non-compliant
- [ ] Tobacco use
- [ ] Alcohol use
- [ ] Drug use (specify in comments box)
- [ ] Other psychosocial risk (specify in comments box)

#### COMMENTS ON PSYCHOSOCIAL RISKS:

#### MEDICAL RISKS:

- [ ] No
- [ ] Yes

- [ ] Anemia (Hgb < 10 or Hct < 30)
- [ ] Sickle cell disease
- [ ] Hypertension (140/90)
- [ ] Diabetes (insulin dependent)
- [ ] Vaginal bleeding (after 12 weeks)
- [ ] Uterine instability
- [ ] Genetic risk
- [ ] Sexually transmitted disease

#### OB HISTORY:

- [ ] Prior premature labor
- [ ] Previous cesarean
- [ ] History of preterm/LBW twins
- [ ] History of fetal/infant death
- [ ] Other medical risk (specify in comments box)

#### COMMENTS ON MEDICAL RISKS:

#### ADDITIONAL COMMENTS:

**IHD USE ONLY** Meets criteria for Healthy Start?  
- [ ] Yes  
- [ ] No

**DHMH USE ONLY**

**DO NOT WRITE IN THIS SPACE**

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**CENTRAL OFFICE COPY 1**
Dental Care for Pregnant Members

Dental services for pregnant women are provided by the Maryland Healthy Smiles Dental Program, administered by Doral Dental. Contact Doral Dental at 888-696-9596 if you have questions about dental benefits.

Childbirth Related Provisions

Special rules for length of hospital stay following childbirth:

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

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

- If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by State law, a home visit must be provided.

- When a member opts for early discharge from the hospital following childbirth, (before 48 hours for vaginal delivery or before 96 hours for C-section) one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.

Post-natal home visits are to be performed by a registered nurse, in accordance with generally accepted standards of nursing practice for home care of a mother and newborn, and must include:

- An evaluation to detect immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress, or other adverse symptoms of the newborn;

- An evaluation to detect immediate problems of dehydration, sepsis, infection, bleeding, pain, or other adverse symptoms of the mother;

- Blood collection from the newborn for screening, unless previously completed;

- Appropriate referrals; and

- Any other nursing services ordered by the referring provider.

If a 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 2 weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit.

**Children with Special Health Care Needs**

Priority Partners will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.

- Provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions, social services, or both, a multi-disciplinary team must be used to review and develop the plan of care for children with special health care needs.

- Refer special needs children to specialists as needed. This includes specialty referrals for children who have been found to be functioning one third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.

- Allow children with special health care needs to access out-of-network specialty providers as specified in the special provisions and guidelines in Section I.

- Log any complaints made to the State or to Priority Partners about a child who is denied a service by us. We will inform the State about all denials of service to children. All denial letters sent to children or their representative will state that recipients can appeal by calling the State’s HealthChoice Enrollee Help Line.

- Work closely with the schools that provide education and family services programs to children with special needs.

- 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 Priority Partners will work together to find another MCO as quickly as possible.

**Individuals with HIV/AIDS**

Children with HIV/AIDS are eligible for enrollment in the REM Program. All other individuals with HIV/AIDS are enrolled in one of the HealthChoice MCOs.
The following service requirements apply for persons with HIV/AIDS:

- An HIV/AIDS specialist for treatment and coordination of primary and specialty care. To qualify as an HIV/AIDS specialist, a health care provider must meet the criteria specified under COMAR 10.09.65.10.B.

- A diagnostic evaluation service (DES) assessment can be performed once every year at the member’s request. The DES includes a physical, mental and social evaluation. The member may choose the DES provider from a list of approved locations or can self-refer to a certified DES for the evaluation.

- Substance abuse treatment 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 enrollees who are individuals with HIV/AIDS to facilities or organizations that can provide the members access to clinical trials.

- The LHD will designate a single staff member to serve as a contact. In all instances, 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 recipient to receive needed health care services.

Case management services are covered for any member who is diagnosed with HIV. These services are to be provided, with the member’s consent, to facilitate timely and coordinated access to appropriate levels of care and to support continuity of care across the continuum of qualified service providers. Case management will link HIV-infected members with the full range of benefits (e.g. substance abuse treatment, primary mental health care, and somatic health care services), as well as referral for any additional needed services, including, specialty mental health services, social services, financial services, educational services, housing services, counseling and other required support services. HIV case management services include:

- Initial and ongoing assessment of the member’s needs and personal support systems, including using a multi-disciplinary approach to develop a comprehensive, individualized service plan;

- Coordination of services needed to implement the plan;

- Periodic re-evaluation and adaptation of the plan, as appropriate; and

- Outreach for the member and the member’s family by which the case manager and the PCP track services received, clinical outcomes, and the need for additional follow-up.
The member’s case manager will serve as the member’s advocate to resolve differences between the member and providers of care pertaining to the course or content of therapeutic interventions.

If a member initially refuses HIV case management services, the services are to be available at any later time if requested by the member.

**Individuals with Physical or Developmental Disabilities**

Before placement of an individual with a physical disability into an intermediate or long-term care facility, Priority Partners will assess the needs of the individual and the community as supplemented by other Medicaid services. We will conduct a second opinion review of the case, performed by our medical director, before placement. If our medical director determines that the transfer to an intermediate or long-term care facility is medically necessary and that the expected stay will be greater than 30 days, we will obtain approval from the Department before making the transfer.

Providers who treat individuals with physical or developmental disabilities must be trained on the special communication 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.

**Individuals in Need of Substance Abuse Treatment**

As part of a member’s initial health appraisal, first prenatal visit, and whenever you think it is appropriate, a substance abuse screen must be performed, using a formal substance abuse screening instrument that is:

- Appropriate for the detection of both alcohol and drug abuse; and
- Recommended by SAMHSA and appropriate for the age of the patient.

When the substance abuse screen yields a positive result, we will arrange for, or the member may self-refer for a comprehensive substance abuse assessment performed by a qualified provider using either:

- The Problem Oriented Screening Instrument for Teenagers (POSIT), or
- The Addictions Severity Index (ASI)

If the comprehensive assessment indicates that the member is in need of substance abuse treatment, a placement appraisal to determine the appropriate level and intensity of care for the member must be conducted. Placement appraisal must be based on the current edition of The American Society of Addictions Medicine Patient Placement Criteria for the Treatment
of Substance-Related Disorders, or its equivalent, as approved by the Alcohol and Drug Administration.

Based on the results of a comprehensive assessment and a placement appraisal, the member is referred to, or the member may self refer to an appropriate substance abuse treatment modality. Substance abuse treatment services covered for all members include:

- Individual, family or group counseling;
- Detoxification (outpatient, or if medically necessary, inpatient);
- Opioid maintenance;
- Intermediate Care Facility-Addictions (ICF-A) intermediate treatment for members younger than age 21;
- Partial Hospitalization; and
- Case management.

We will not deny substance abuse treatment solely because the member has had a problem with substance abuse in the past. In addition, individuals in certain special populations are covered for some additional substance abuse services, specifically:

**Pregnant and postpartum women:**

- Access to treatment within 24 hours of request;
- Case management; and
- Intensive outpatient programs, including day treatment that allows for children to accompany their mother.

**Individuals with HIV/AIDS:**

- Individuals with HIV/AIDS who are substance abusers will receive substance abuse treatment within 24 hours of request.

**Individuals who are Homeless**

If an individual is identified as homeless, we will provide a case manager to coordinate health care services.

**Adult Members with Impaired Cognitive Ability/Psychosocial Problems**
Support and outreach services are available for adult members needing follow-up care who have impaired cognitive ability or psychosocial problems and who can be expected to have difficulty understanding the importance of care instructions or difficulty navigating the health care system.

- Outreach efforts to bring the member into care must be documented in the medical record. These efforts may include, but may not be limited to, attempts to notify the member by mail, by telephone and through face-to-face contact.

- Within 10 days of either the third consecutive missed appointment, or of the member’s provider becoming aware of the member’s repeated non-compliance with a regimen of care, whichever occurs first, the provider will make a written referral to the LHD Administrative Care Coordination Unit (ACCU) using the Local Health Services Request Form requesting its assistance in locating and contacting the members for the purpose of encouraging the members to seek care.

After referral to the ACCU, the member’s provider will work collaboratively with the ACCU and MCO to bring the member into care.
PRIORITY PARTNERS SUPPORT SERVICES

Outreach

Priority Partners’ Outreach Services provide clear communication mechanisms to expedite linkages to community-based resources that address the needs of our members. Requests for outreach services may be generated from members, PCPs, specialty providers, Care Coordinators, Case Managers, members’ friends and family.

Requests for Outreach Services may be submitted telephonically, electronically (via the website) or by faxing in a completed Outreach Services Referral Form.

- Phone  410-424-4648 or 888-500-8786
- Fax      410-424-4884
- oreferrals@jhhc.com

Outreach Services

- Notification of members for upcoming health maintenance activities and written reminders of appointment dates to ensure scheduling of initial appointment within specified guidelines for targeted populations.

- Follow-up on all members (with missed appointments) by telephone or letter to include rescheduling of the missed appointment within 30 days or as appropriate.

- Schedule necessary and mandated referrals and collaborate with the Local Health Departments.

- Work with local Social Service departments in obtaining solutions to resolve social issues.

- Work collaboratively with Care Coordinators in the coordination and implementation of member’s care plans.

- Coordinate and/or arrange transportation.

- Coordinate and/or arrange interpretation services, including services for the hearing impaired.
Special Needs/Enhanced Care Management (Care or Case)

Care Management is an intensive coordination and evaluation of care that is appropriate when a member is part of a special needs population.

Enhanced case management services are available for members who are part of a special needs populations including:

- Children with special health care needs
- Children in State-supervised care
- Individuals with a physical disability
- Individuals with a developmental disability
- Pregnant and postpartum women
- Individuals who are homeless
- Individuals with HIV/AIDS
- Individuals with a need for substance abuse treatment.

For assistance in coordinating care for a special needs member, contact the Special Needs Coordinator at 410-424-4906 or 800-261-2396 ext. 4906, or fax a completed Priority Partners Managed Care Organization Special Needs Referral form to 410-424-4887.

Health Education

In addition to Outreach and Special Needs Services, the Priority Partners Health Educator is a resource for providers that can include the following educational methods:

- Individual member health education for special needs populations and those referred by the PCP as having problems following a plan of care.
- Provisions for individual and group health education and health promotion activities.
- Participation in community-based health screening programs for Priority Partners members.
- Collaboration with Care Coordinators and Case Managers in providing member education, reinforcement of member participation in the treatment plan and follow-up of missed appointments.
- Serve as a member’s advocate.
- Facilitate member’s participation on the Priority Partners’ Consumer Advisory Board.

The Priority Partners Health Educator can be contacted at 410-424-4821 or 866-438-8911 or by faxing a completed Priority Partners MCO Referral to Health Educator Form to 410-424-4896.
MEDICAL RECORD STANDARDS

It is the policy of Johns Hopkins HealthCare LLC (JHHC) to ensure that the medical records of network practitioners are maintained in a manner that is current, detailed, organized, permits effective and confidential patient care and quality review, and meets established goals for medical record keeping.

The JHHC standards for medical record documentation include the following:

Confidentiality of Medical Records:
- Medical records are stored securely
- Only authorized personnel have access to records
- Medical practice has a policy that ensures the staff receive training in member information confidentiality

Each medical record must include:
- History and physicals
- Allergies and adverse reactions
- Problem list
- Medications
- Documentation of clinical findings and evaluation for each visit
- Preventive services/risk screening
- Documentation of follow-up for all diagnostic, therapeutic, and ancillary services

Availability of medical records:
- Medical records are organized and stored in a manner that allows easy retrieval
- Medical records are stored in a secure manner that allows access by authorized personnel only

JHHC will conduct medical record documentation reviews on a randomly selected sample of primary care practitioners. Those practitioners who document in EMR or who have received recognition in NCQA’s Physician Practice Connections Program will be excluded from reviews.

JHHC has set the following performance goals for reviews of medical record documentation:

<table>
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<th>Category</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Best Practice</td>
<td>80% to 100%</td>
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<tr>
<td>Acceptable</td>
<td>50% to 79%</td>
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<tr>
<td>Not Acceptable</td>
<td>0% to 49%</td>
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REFERRAL/AUTHORIZATION PROCESS

The Primary Care Provider (PCP) is responsible for determining when a member’s health care needs exceed his/her scope of practice and directs the member’s care to other providers to meet specific member care goals.

Referrals for all services must be made to participating Priority Partners providers. Consult the Priority Partners Provider Directory search function on www.ppmco.org for participating specialist, facility and ancillary providers.

REFERRAL PROCEDURES FOR PRE-AUTHORIZATION BY CARE MANAGEMENT

Referrals may be telephoned, faxed or mailed to the Care Management Department.

- Phone 410-424-4480 or 800-261-2421
- Fax 410-424-4603 - Referral not needing Medical Review
- Fax 410-424-4894 - Inpatient
- Fax 410-762-5205 - Outpatient Medical Review

- Mail to: Johns Hopkins HealthCare LLC
  6704 Curtis Court
  Glen Burnie, MD 21060
  Attn: Priority Partners Care Management

Regardless of the process used to notify Priority Partners of the referral, the PCP must communicate to the specialist the reason for and the parameters of the referral.

- PCPs must provide specialists with pertinent lab and x-ray results.
- Key Referral Information: Patient name, DOB, member’s MCO ID number, address, referring physician, referred services, reason for referral, and any limitations on referral.
- PCPs must specify the time span and number of visits up to a maximum of 50 visits in one year from the date of the referral. If the time span and number of visits are not specified by the PCP, the referral will default to one visit within 120 days of the date the referral was written. Referrals which require Medical Review (pre-authorization) may have the number visits and date spans changed per Johns Hopkins HealthCare policy.
Telephone Referrals

The PCP or designated staff may call in a referral 24 hours a day, 7 days a week by calling 410-424-4480 or 800-261-2421. After regular business hours, or if all the referral coordinators are busy, the following required information may be left in the Care Management confidential voice mailbox:

- Member’s name
- Member’s Priority Partners ID number
- Specialist’s name and NPI number
- Diagnosis/Reason for Referral
- Services authorized (e.g. Consultation only, Consultation and testing, Consultation, testing and treatment)
- Time span for the referral
- Any limitations on the referral

Written Referrals

The PCP or designated staff may utilize the Maryland Uniform Consultation form as a convenience to provide written documentation for the member, the PCP and the Specialty Provider. To refer a member using the form, the first copy should be given to the member, the second copy should be forwarded to the specialist and the third copy should be mailed directly to Priority Partners.

Faxed Referrals

The completed Maryland Uniform Consultation Referral form may be faxed directly to Priority Partners. The PCP should retain the referral form in the member’s medical record with the fax confirmation. It is the responsibility of the PCP to inform the member and specialist of the limitations on referrals.

Out-of-Network Referrals

All out-of-network referrals require the approval of Care Management. Out-of-network referrals based on Medical Necessity require the approval of the Priority Partners’ Medical Director.

Out-of-network referral requests, with appropriate clinical information, should be faxed to the Care Management Department/Medical Review at 410-762-5205.
Urgent requests will be responded to within one business day. Non-urgent requests will be responded to within seven calendar days.

**Late Referrals**

For the purposes of tracking and trending, referrals *not* requiring pre-authorization submitted to Priority Partners after 180 days will be redirected to the Provider Relations Department for educational purposes and must be submitted to appeals for review.

**Referral Extensions**

Referrals for specialty care can be extended for a number of visits, or beyond the original date of service by a phone, fax or written request. The request can be submitted by the PCP or specialist to Care Management. If the specialty services require Medical Review (pre-authorization), clinical notes and/or treatment plans may need to be submitted with the request for additional visits to be authorized.

**Inpatient Admissions**

The PCP may refer or admit within the network with pre-authorization for medically necessary procedures/diagnoses.

Inpatient admissions which have not been pre-authorized will be reviewed for medical necessity from the date of notification through discharge. If notification is not received within 2 business days of the admission, the day’s prior to notification will be denied unless there are documented extenuating circumstances.

Once notification of an admission is received, and throughout the hospital stay, the utilization management staff will request clinical information on the patient to certify continued stay as an inpatient. If requested information is not received within two business days of the request, the days will be administratively denied for lack of clinical information.

All elective admissions are reviewed to determine if the service could be provided in an ambulatory setting and meet the criteria. The Care Coordinator, based on consultation with the Medical Director, will notify the requesting provider of an adverse decision and discuss alternatives.

**PRE-AUTHORIZATION PROCESS**

The PCP or designated staff notifies the Priority Partners Intake Coordinator at 410-424-4480 or 800-261-2421 prior to admission.

The Intake Coordinator obtains the following information for the admission:

- Patient Name
- Priority Partners ID Number
- Admitting Physician
Hospital Name and Address
Admission Date
Diagnosis and clinical information
Procedure
Name and Telephone Number of Contact Person
Tax Identification Number (TIN)

The Priority Partners Intake Coordinator reviews the information for authorization entry process. Specific surgical procedures may require review by the Medical Director for determination of coverage.

When a provider requests an authorization for a member, and JHHC approves that authorization, the provider needs to notify the member that their authorization has been approved.

Free Communication with Members

As stated in the Johns Hopkins HealthCare LLC Participating Provider Agreement: Nothing in this Agreement nor any Payor Addenda shall preclude or restrict Provider from discussing or communicating to Covered Persons, public officials, or other individuals, information that is necessary or appropriate for the delivery of health care services, including: communications that relate to treatment alternatives, REGARDLESS OF BENEFIT LIMITATIONS; communications that are necessary or appropriate to maintain the provider-patient relationship while the Covered Person is under the Provider’s care; communications that relate to a Covered Person’s right to appeal a coverage determination with which the Provider or Covered Person does not agree; and opinions and the basis of an opinion about public policy issues.

Hospital Notification

Hospitals are required to notify Priority Partners within 2 business days of a member’s admission.

Medical Necessity

Medical necessary means that the service or benefit is:
(See COMAR 10.09.62B.107)

- Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

- Consistent with current accepted standards of good medical practice

- The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
• Not primarily for the convenience of the consumer, the consumer’s family, or the provider.

A medically necessary service is a service which:

• Provides for the diagnosis, prevention, or care of a covered medical condition.

• Is appropriate and necessary for the diagnosis, prevention or treatment of a covered medical condition.

• Is within standards of good medical practice recognized within the organized medical community.

• Is not provided primarily for the convenience of the member or the provider.

• Is the most appropriate level of service or supply which can be provided safely.

Medical necessity is determined using criteria developed from the following information sources:

• Medical/Scientific literature
• Standards and guidelines from professional associations and/or government agencies
• Specialty Peer Review Panels
• Medical Director Review
• Managed Care Consultants

The criteria for medical necessity is reviewed and updated annually by the Scientific Assessment and Benefit Advisory Committee.

Medical Necessity Criteria will be applied to all inpatient admissions and to all provisionally covered services.

**Cases will be referred to the Medical Director for the following reasons:**

• Submitted documentation is unclear as to whether medical necessity criteria have been met.

• Submitted documentation does not meet the medical necessity criteria.

A decision will be made upon receipt of required documentation, within two days for non-urgent care, and one day for urgent care.

Members and providers will be notified in writing when services are denied partially or in full. The notification will include reasons for the denial, instructions on obtaining additional information, and the Appeals Process.
SERVICES REQUIRING PRE-AUTHORIZATION FOR MEDICAL NECESSITY

The following services listed below either require pre-authorization, a referral or are Direct Access. For services that require pre-authorization, the PCP and/or Specialist must obtain authorization prior to rendering services. All services that require a referral must be on file prior to claims submission. All Out-of-Network providers require pre-authorization.

Fax for Outpatient Intake Services  410-424-4603.
Fax for Pre-Authorization  410-762-5205.

Audiology – Audiology for adults is not covered except inpatient. For members over 21 years of age, a referral is no longer needed from the PCP. For members 21 years old and younger, services are carved out to the State.

Physical/Occupational Therapy – For members over 21 years of age, a pre-authorization is required after first 6 visits. The initial 6 visits require the referral to be faxed to Care Management for an authorization number to be generated. For members 21 years old and younger, services are carved out to the State.

Speech Therapy – For members over 21 years of age, all speech services require pre-authorization prior to rendering services. For members 21 years old and younger, services are carved out to the State.

Chiropractic Care – A covered benefit only for children 21 years of age and under and requires pre-authorization. This is not a covered benefit for those over 21 years of age.

Services Requiring Clinical Information for Prospective Review

- Admission to Physical Rehabilitation
- Admission to Skilled Nursing or Transitional Care Facilities
- Admission to non-participating facilities by participating providers
- Procedures requiring medical benefit determination
- Services that are potentially investigational or experimental
- All procedures requiring pre-authorization listed on the Priority Partners Outpatient Referral and Pre-Authorization Guidelines.

Maternity Notification

- When a Priority Partners member presents at a provider’s office for prenatal care, the OB/GYN provider or PCP must call Priority Partners’ Utilization Management Department at 410-424-4480 or 800-261-2421 or fax the notification using the Maryland Uniform Consultation form to 410-424-4603.

- The provider will be given an authorization number, via fax or phone, for submission of claims.
• The authorization will cover all routine blood work, routine diagnostic tests (e.g. NST, sonograms performed in the provider’s office), routine office visits, delivery and the 6-week post partum visit.

• The authorization will begin with the date of the first visit and will remain effective for two months post delivery date.

Second Opinions

Second opinions are covered and should be coordinated through the PCP.

Emergency Care

An emergency is defined as a medical condition characterized by sudden onset of symptoms, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

• Placing the patient’s health in serious jeopardy;
• Serious impairment of bodily functions; or
• Serious dysfunction of any bodily organ or part.

In the event of an emergency, the member should proceed directly to the closest emergency facility.

Emergency Department Protocol for Hospitals

Emergent

• If the member is referred for emergency service by his or her PCP, the PCP or the designated staff must notify the Care Management Referral Line or the After Hours Triage Line within 24 hours or one business day of the referral.

• Treatment should be initiated and the member’s condition stabilized. The member should be directed to coordinate follow-up care through their PCP. If the Emergency Department is concerned that the patient will not comply with appropriate follow-up care, a request for Outreach Services should be initiated by calling 410-424-4648 or 888-500-8786.

• If hospital admission is indicated, the member’s PCP must be contacted to authorize admission.

• In the event that the member’s PCP cannot be reached, the member should be admitted per the hospital’s standard procedures. The Emergency Department physician or designee should contact the Priority Partners Care Management Line and speak with the on-call Care Coordinator or leave a message outlining the admission and inability to contact the member’s PCP.
• Notification of an emergency inpatient admission by the admitting facility of admission must be made within 24 hours or the next business day after the admission if it occurs during a weekend or on a holiday. Notification is required to authorize the inpatient stay. The days between admission and notification will not be authorized unless there are documented extenuating circumstances that prevented notification.

• The days after notification will be reviewed for medical necessity and the medically necessary days will be authorized if the Care Management staff continues to receive updated clinical information on the patient's condition. If requested information is not received within two business days of the request, the days will be administratively denied for lack of notification.

  o If a claim is received and there is no notification in the system, the claim will be denied. If the denial is within 30 days of receipt of the claim, no interest is paid on the claim. The claim is deemed not clean because authorization was required and not supplied.

  o The provider is permitted to appeal the denial. The provider is given the opportunity to provide evidence of notification. If no evidence is produced, the claim will remain denied.

Urgent

• If urgent care is indicated, Medical Assessment/Screening should be completed and the member’s condition stabilized. The member should be directed to coordinate follow-up care through the PCP.

• No authorization is required for participating urgent care facilities.

• If there are any concerns that the member will not comply with appropriate follow-up care, a request for Outreach Services should also be initiated by calling 410-424-4648 or 888-500-8786.

Non-Urgent

• Medical Assessment/Screening should be completed.

• If urgent care is not indicated, the member should contact the PCP (listed on the identification card). If there are any concerns that the member will not comply with appropriate follow-up care, a request for Outreach Services should also be initiated by calling 410-424-4648 or 888-500-8786.
Substance Abuse

Coverage is coordinated and pre-authorized for outpatient and inpatient care by Behavioral Health Services at 410-424-4476 or 800-261-2429.

Specialty/Crisis Mental Health

Contact the Department’s Specialty Mental Health Systems Administrative Services Organization (ASO) at 800-888-1965.

Out-of-Network Hospital Emergency Departments

If hospitalization is indicated, the Emergency Department Physician or designee must contact the Priority Partners’ on-call Care Coordinator prior to admission. The Care Coordinator will work with the hospital physician staff, the Priority Partners’ Medical Director and the member’s PCP to determine if a transfer to a network facility is appropriate. The Care Coordinator is also available to assist in coordinating transfer arrangements.

If the Care Coordinator is not contacted prior to admission, all services will be reviewed concurrently for coverage determination. If it’s determined that the member could have safely transferred to a Priority Partners network facility, no reimbursement will be provided for that hospitalization. If concurrent review is not possible due to lack of notification of Priority Partners, no payment will be provided for services rendered.

After Hours Care Coordination

PCPs may leave referral information in the Care Management confidential voice mailbox to be processed the following business day.

On call Care Coordinators are available outside of normal business hours from 5 p.m. to 8 a.m., seven days a week for urgent request from hospitals, DME or Home Health providers at 410-379-8830.

Disease/Case Management

Disease/Case Management is a multi-disciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for established medical conditions and professionally manages these members in a manner that improves care, promotes wellness and manages/reduces cost.

The goal of Disease/Case Management is to achieve improved patient outcomes by providing intensive education and monitoring which supports the physician’s treatment plan.

Priority Partners’ Disease Managers are responsible for Disease/Case Management activities for Priority Partners members. The Disease Manager:
• Assesses the disease
• Monitors the symptoms of the disease by detecting signs of worsening disease symptoms
• Informs members and physicians of the members' benefits
• Identifies possible treatment options to give members more choices
• Arranges and coordinates needed services
• Fosters member independence

The following target programs are the focus of Disease/Case Management efforts:

• Partners with Mom (high risk OB)
• Positive Health Partners- a program for members with HIV/AIDS
• Your Partner in Health - Asthma (Children and Adults)
• Pediatric Health Partners including NICU
• Partners for a Healthy Heart and Body
• End Stage Renal Disease
• Physical Rehabilitation

Member Identification

Members are identified for targeted Disease/Case Management interventions through the following mechanisms:

• Claims and encounters
• Pharmacy data
• Laboratory data
• PCP, hospital staff and other referrals from the healthcare team
• Utilization Management staff
• Member-self referral
• Predictive Modeling using ACGs (Adjusted Clinical Groups) developed by the Johns Hopkins Health Research and Development Center

Treatment Planning

The Care Manager will review the case with the PCP and record a brief medical history, identify what health promotion and maintenance services are currently being provided, and what alternative care is appropriate.

The Care Manager and the PCP will determine what additional services, and/or alternative care would benefit the members.
If needed, the Care Manager implements the new services including discussion with the members, setting up services with network providers, determining data elements to be collected and time frames for re-evaluation.

Data will routinely be collected (using concurrent and retrospective review and reporting) to evaluate the effectiveness and efficiency of care.

The PCP will work with the Care Manager by communicating any significant changes in the member’s condition, problems with service delivery, and working with alternative care opportunities for the members.

The Care Manager will enter significant changes in the member’s health status, new treatments or services, into a database and continually insure that the appropriate level of care management is in place. The Care Manager will also communicate regularly with any healthcare team of providers involved in the member’s care to ensure that the care remains a covered benefit, and recommend changes to the plan of care to the PCP.

Identified patient care issues outside medical policy guidelines will be brought to the attention of the PCP/admitting physician and the Priority Partners Medical Director.

Accessing Disease/Case Management Programs

Disease/Case Management Services may be accessed by calling 410-424-4480 or 800-261-2421.

Disease/Case Management and Special Care

Priority Partners members with complex medical needs are able to receive special care designed to help them understand and manage their conditions.

Diabetes, heart failure, asthma, cancer and other chronic diseases often require more patient education and ongoing support than a provider can offer. That is why our highly trained nurse case managers stand ready to help by coordinating care, serving as personal advocates and providing ongoing support to help patients learn to care for themselves and monitor their health.

Nurse case managers can help with:
• Scheduling doctor appointments and obtaining referrals
• Coordinating specialty care
• Obtaining medical equipment and supplies
• Providing health education
• Understanding and using Priority Partners benefits

All of our Disease/Case Management programs are voluntary and are specifically designed to meet the needs of each individual member. Case Managers visit members at home, in the hospital, and sometimes accompany members to the provider in order to learn about...
and support the provider’s plan of care. The relationship formed between the member and the case manager is often lasting and includes family members and other support systems.

The following programs are available to Priority Partners members:

- **Partners with Mom** – for mothers experiencing high risk pregnancy.

- **Pediatric Health Partners** – for children with medical problems such as diabetes, complications of prematurity, congenital problems, sickle cell, obesity, neurological problems or genetic syndromes, among others. Issues such as SSI and REM eligibility are explored.

- **NICU** – for babies in the Neonatal Intensive Care Unit.

- **ESRD** (End State Renal Disease) – for members on dialysis to treat kidney disease.

- **Complex Medical** – for members having special needs or complex chronic conditions such as asthma, COPD, diabetes, high blood pressure, morbid obesity.

- **Telemedicine** – for members with heart failure, or diabetes with coronary artery disease, peripheral vascular disease, diabetic retinopathy or hypertension.

- **Rehabilitation** – for adult members with rehabilitation needs such as spinal cord injury, traumatic brain injury, severe burns, or a motor vehicle accident.

- **Omega Life** – for members who have received a cancer diagnosis.

- **Positive Health Partners** – for members with HIV and AIDS.

- **Behavioral Health** – for members in need of substance abuse treatment.

Priority Partners members can be evaluated by the Care Management at enrollment, during hospital admissions, upon receiving complex in-home care, when health claims indicate a special need, or when the member requests case management.

For more information about any of the disease/case management programs, call 800-557-6916 or send an e-mail to casemanagement@jhhc.com.

**Specific Complex Medical Case Management**

Your Partner in Health, a program for members with complex medical needs, offers intensive coordination of care when a member’s health care needs are of high acuity or complexity, but the member does not meet Disease/Case Management Criteria.
Examples include members suffering from the following:

- COPD/Asthma
- Cardiovascular disease
- Chronic lung conditions
- Diabetes – Type I and Type II
- Severe and persistent pain
- Seizure disorders
- Sickle cell anemia
- Multiple medical problems
- Developmental disabilities
- Morbid Obesity

Episodic Case Management is provided for a period of up to three months for members whose health care needs are a low acuity. Examples of diagnosis for short term management are:

- Newly diagnosed Diabetes or Hypertension
- Pyelonephritis
- Routine fracture care
- Cellulitis
- Deep Vein Thrombosis
- Members that receive new CPAP therapy
- Members on short-term antibiotic therapy
- Burns, second degree

**Population Health Programs and How to Refer**

Priority Partners has a full scope of population health programs to help members manage chronic health conditions, recover from serious illness and make healthy lifestyle changes. Our Population Health Initiative 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.

If you have questions about the programs or have a member who would benefit from these services, you can make a referral by calling 410-762-5206 or toll free at 800-557-6916. We are available Monday through Friday from 8:30 a.m. to 5 p.m. Any voicemail messages received after normal business hours will be addressed the following business day. We can also be contacted via e-mail at populationhealth@jhhc.com
**Priority Partners Formulary**

Priority Partners has a closed formulary, which should be used when prescribing for members. Only those drugs listed in the formulary are covered. The drugs listed in the formulary are intended to provide sufficient options to treat 95% of the patients who require treatment with a drug from that pharmacologic or therapeutic class. The drugs listed have been reviewed and approved by the Priority Partners Pharmacy and Therapeutics Committee, and were selected to provide the most clinically appropriate and cost-effective medications for patients who have their drug benefit administered through Priority Partners.

To receive a copy of the Priority Partners formulary booklet, please contact the Provider First Line at 888-819-1043 or your Network Manager at 410-762-5385 or 888-895-4998.

**Medical Exception Process**

There may be occasions when an unlisted drug is desired for medical management of a specific patient. In those instances the unlisted medication may be requested through the Medical Exception Process. Exceptions may be requested by completing the Non-formulary/Prior Authorization Request Form and by faxing it to 410-424-4607.

**Request for Formulary Addition**

The formulary is updated annually. To submit a request for consideration of an addition to the formulary, either during the annual review or between reviews, mail a Formulary Additions and Deletions form to:

Priority Partners  
6704 Curtis Court  
Glen Burnie, MD 21060  
Attn: Chairperson, Pharmacy and Therapeutics Committee

In addition to prescription benefits, various over-the-counter medications are covered by Priority Partners with a written or verbal prescription from a Network Provider.

**Pharmacy Services**

As a provider, it is critical to explain the proper utilization of pharmacy services to your patients, including the following:

- It is important that members understand that they might need both their Priority Partners identification card and their regular Medicaid card when filling a prescription.
• It is important for members to always use the same pharmacy within the Priority Partners network to fill all of their prescriptions. This enables the pharmacist to know about possible problems that may occur when a member is taking more than one medication.

• Members should always present their Priority Partners identification card when they have a prescription filled. They will also need to present their Medical Assistance identification card for drugs prescribed by their mental health provider.

BILLING INFORMATION

Physician Fees

Providers should bill their customary fee for covered services which are not reimbursable under capitation. These services will be reimbursed according to the terms of the Priority Partners Payor Addendum.

Coordination of Benefits/Co-Pays

When Priority Partners members have other insurance, including Medicare, the other insurance must be billed as the primary payor. As the secondary payor, Priority Partners is responsible to pay within our allowable payment amount* for co-pays, deductibles and other services covered under the HealthChoice benefit which are not covered under the primary plan. Priority Partners members should not be billed for co-pays or deductibles. These charges should be billed directly to Priority Partners. Priority Partners does not routinely reimburse members for out-of-pocket expenses. To expedite claims payment, providers should first submit claims to the primary insurance carrier and then submit a claim to Priority Partners with the primary carrier remittance attached. Claims will be paid based on allowable payment amount*.

Subrogation (MVA)

Priority Partners requires providers to seek reimbursement from the responsible third party when a third party is liable, for example motor vehicle accidents or workmen’s compensation claims. If a potential TPL claim is submitted to Priority Partners, it will be paid normally. If, however, it is later discovered that a third party is liable for the charges Priority Partners will retract any monies paid and send the provider a letter advising them to bill the responsible party.
Claims Submission

Claims or encounter data should be filed on a standard CMS 1500 claim form. Facilities should submit claims on a UB-04 form.

Claims must be submitted within 180 days of the date of service to the address below:

Johns Hopkins HealthCare
6704 Curtis Court
Glen Burnie, MD 21060
Attn: Priority Partners Claims

If you would like to submit claims electronically, email providerrelations@jhhc.com for additional billing information.

Attachments to a CMS 1500 form or UB-04 form, which may be required, and the circumstances under which they may be requested are:

- A referral or consultant treatment plan;
  - Referrals may be required for an “appeal” of a claim denied for “failure to coordinate care with PCP”. Treatment Plans may be required for certain specialty services such as physical therapy, mental health, substance abuse treatment, etc.

- An explanation of benefits statement from the primary payor;
  - Required if JHHC is the secondary payor.

- A Medicare Remittance Notice;
  - Is required if the claim involves Medicare as a primary payor.

- A description of the procedure or service, which may include the medical record;
  - May be required if a procedure or service rendered has no corresponding CPT or HCPCS code.

- Operative notes;
  - May be required if the claim is for multiple surgeries, or includes modifier 22, 58, 62, 66, 78, 80, 81 or 82.

- Anesthesia records documenting the time spent on the service;
  - May be required if the claim for anesthesia services rendered includes modifiers P4 or P5.

- Documents referenced as contractual requirements in a global contract;
  - May be required if there is a global contract between JHHC and a health care practitioner, hospital, or person entitled to reimbursement.

- An ambulance trip report;
• May be required if the claim is for ambulance services submitted by an ambulance company licensed by the Maryland Institute for Emergency Medical Services Systems;

• Office visit notes;
  o May be required if the claim includes modifier 21 or 22, or an audit of the health care practitioner, hospital, or person entitled to reimbursement demonstrated a pattern of fraud, improper billing or improper coding.

• Admitting notes, except in the case of emergency services rendered in accordance with Health-General Article, §§190701(d) and 19-712.5, Annotated Code of Maryland;
  o May be required if the claim for services provided is outside of the time or scope of the authorization, or when there is an authorization in dispute.

• Physician notes, except in the case of emergency services rendered in accordance with Health-General Article, §§190701(d) and 19-712.5, Annotated Code of Maryland;
  o May be required if the claim for services provided is outside the time or scope of the authorization, or when there is an authorization in dispute; and

• Itemized bill, except in the case of emergency services render in accordance with Health-General Article, §§190701(d) and 19-712.5, Annotated Code of Maryland;
  o May be required if the service is rendered in a hospital and the hospital claim has no prior authorization for admission, or is inconsistent with JHHC/MSC concurrent review determination rendered before the delivery of services, regarding the medical necessity of the service.

• Administrative Days must be billed separately from acute hospital days and the DHMH 1288 form, Report of Administrative Days, must be attached.

**Obstetrical Care Services Billing**

A global OB authorization must be on file for correct claims payments. The global OB authorization covers routine OB services provided in the provider’s office, such as NSTS, lab tests, etc.

Priority Partners does not reimburse global fees for OB care. Services for deliveries must be billed separately from prenatal care. Vaginal deliveries are generally billed using CPT code 59409 or 59410. Cesarean deliveries are generally billed using CPT code 59514 or 59515.

To bill for prenatal care services, you may use the appropriate evaluation/management code for each visit. In general, the first prenatal visit will be the most detailed and comprehensive and follow-up visits will be less comprehensive and require less time.
Use ICD-9 code V22.0 – V22.2 (normal pregnancy) or V23.0 – V23.9 (high-risk pregnancy) for prenatal care visits.

Other medically necessary services related to prenatal care, such as lab tests, and sonograms will also be reimbursed. **Remittance Advice Statement**

The items below correspond with the Remittance Advice Form which follows. Together, they provide specific information regarding the review and interpretation of the Priority Partners Remittance Advice.

This remittance is used for all providers who submit claims to Priority Partners. Thus, there may be sections that are not applicable for posting and reconciliation of certain claims.

<table>
<thead>
<tr>
<th><strong>Payee</strong></th>
<th>The name and address of the payee as indicated on the submitted claim</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Check Date</strong></td>
<td>The date the check (if any) was prepared.</td>
</tr>
<tr>
<td><strong>Payee Number</strong></td>
<td>The payee’s tax identification number.</td>
</tr>
<tr>
<td><strong>Check Number</strong></td>
<td>The number of the check (if any).</td>
</tr>
<tr>
<td><strong>Date of Service</strong></td>
<td>The “from and to” dates submitted on the claim.</td>
</tr>
<tr>
<td><strong>Procedure Code</strong></td>
<td>Procedure/revenue code that best describes service rendered.</td>
</tr>
<tr>
<td><strong>Billed Amount</strong></td>
<td>The amount identified by the provider as a charge for a service or procedure.</td>
</tr>
<tr>
<td><strong>Charges Above Max</strong></td>
<td>The portion of the billed amount that is in excess of the established fee maximum for the procedure. This amount is NOT a member’s liability.</td>
</tr>
<tr>
<td><strong>Disallowed Amount</strong></td>
<td>The dollar value of a service which is not eligible for payment. A disallowed amount is not a deductible, co-insurance or co-payment. It may represent that portion of the charge above the benefit maximum (and would not be a member's liability) and/or the charge for a non-covered procedure (which would be a member’s liability).</td>
</tr>
<tr>
<td><strong>Allowed Amount</strong></td>
<td>The amount eligible for payment.</td>
</tr>
<tr>
<td><strong>Deduct/Co-pay/Coins</strong></td>
<td>Identifies the member’s liability for cost-sharing features (deductible, co-payment and/or co-insurance) of the program.</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Other Insurance Paid</strong></td>
<td>The total dollar amount paid by any other insurance carrier or Medicare.</td>
</tr>
<tr>
<td><strong>Subscriber Liability</strong></td>
<td>The dollar amount which the provider may collect from the subscriber. This amount includes any applicable deductible, co-payment, co-insurance and charges for non-covered services.</td>
</tr>
<tr>
<td><strong>Net Payable</strong></td>
<td>The total dollar amount being paid for the procedure. The Allowed Amount minus deductible/co-payment/coinsurance minus Other Insurance Paid Equals Net Payable.</td>
</tr>
<tr>
<td><strong>Remark Code</strong></td>
<td>The code number that identifies a message to the provider regarding payment of the claim. Codes are defined at the end of the remittance.</td>
</tr>
<tr>
<td><strong>EPSDT</strong></td>
<td>Indication whether billed procedure is related to Early, Periodic Screening, Diagnosis and Treatment (EPSDT) services.</td>
</tr>
<tr>
<td><strong>Provider Name</strong></td>
<td>The name of the provider who provided services for a submitted claim.</td>
</tr>
<tr>
<td><strong>Provider ID</strong></td>
<td>The identification number assigned to the specific provider submitting the claim.</td>
</tr>
<tr>
<td><strong>Line of Business</strong></td>
<td>The code indicating in which line of business the patient is a member. Priority Partners’ line of business code is 300.</td>
</tr>
<tr>
<td><strong>Claim Total</strong></td>
<td>The total dollar value of all individual line items submitted on a single claim.</td>
</tr>
<tr>
<td><strong>Payable Total</strong></td>
<td>The total of all payable claims included in the remittance advice.</td>
</tr>
<tr>
<td><strong>Remittance Total</strong></td>
<td>The overall total of all claims included in the remittance advice.</td>
</tr>
<tr>
<td><strong>Remark Code</strong></td>
<td>Definition of all remark codes indicated on the remittance.</td>
</tr>
</tbody>
</table>
PRIORITY PARTNERS QUALITY MANAGEMENT

1. **Purpose:**
The purpose of the Quality Improvement Program at JHHC is to provide a comprehensive process for the management of potential and actual quality of care and service related issues. It is dedicated to ensuring the JHHC mission of providing an excellent managed care infrastructure, thereby striving to improve the quality of patient care while reducing the cost. It is a continuous process by which quality is assessed, opportunities for improvement are identified, corrective action plans are implemented, and effectiveness is evaluated.

2. **Definition:**
Healthcare Quality Improvement is a continuous process undertaken to ensure that individuals and groups of patients receive care of the highest standards, and represents current best practices. These processes maximize member satisfaction and safety; optimize healthcare outcomes and overall improved provider satisfaction with the health plan services.

3. **Scope:**
The scope of the Quality Improvement Program is to improve areas involving both the service component and clinical aspects of care. This effort encompasses the continuum of the care delivery system: inpatient, outpatient, skilled nursing, rehabilitation, and emergency services. It also includes the services which encompass monitoring; customer service, member satisfaction, and provider satisfaction with health plan services. In all activities, the Quality Improvement Program ensures compliance with applicable accreditation standards, and state and federal regulations.

4. **Responsibility and Accountability:**
The Board of Directors of Johns Hopkins HealthCare LLC is responsible for the overall Quality Improvement Program. In meeting this responsibility, the Board has delegated oversight of the Quality Improvement Program to the President. The Senior Director of Quality Improvement and Member Initiatives is responsible for implementation and monitoring of the Quality Improvement Program.

5. **Program Evaluation:**
The program is reviewed annually to assure achievement of goals established by the Quality Improvement Committees, QIOC (Quality Improvement Oversight Committee, PMT (Process Management Team) and PROFAC (Professional Advisory Committee). The results will be analyzed to determine the effectiveness of the interventions for improvement in patient care and service outcomes. The plan, its objectives and activities, will be revised or enhanced for the upcoming year as directed by the analysis of the data collected. This evaluation will take into account the various program descriptions and work plans. The revised Quality Improvement Program is presented to the Board of Directors annually once approved by the Quality Improvement Committees. Once approved internally, the plan, including appropriate addendum, is forwarded to regulatory agencies as required.
Mission Statement

The Mission of the Quality Improvement Program is to:

- Ensure that all activities meet accreditation standards, state and federal regulations and contract requirements.
- Evaluate services and care delivery with respect to outcomes (e.g. member and provider satisfaction)
- Analyze plan outcomes as compared to national industry benchmarks
- Identify opportunities for improvement in both the clinical and service areas
- Evaluate the overall effectiveness of the program on a yearly basis

QUALITY IMPROVEMENT PLAN

Objectives

The Quality Improvement Objectives have been developed from an analysis of the information available and specific to the PPMCO members at Johns Hopkins.

- Continue to monitor member and provider satisfaction and identify opportunities for improvement through data analysis from the annual Member and Provider Satisfaction Surveys.
- To maintain Full Accreditation status through continued compliance with URAC Health Network standards.
- To improve Claims Processing by keeping the percent of claims processed in less than 30 days above 90% while maintaining accuracy scores above 98%.
- To meet or exceed organizational performance standards for Customer Service.
- To monitor participation of PPMCO members in the various Disease Management Programs.
- To continue to monitor the HEDIS measures annually as selected by the Department of Health and Mental Hygiene (DHMH).
- To maintain compliance with the Comprehensive Quality Management Program through the JHHC Quality of Care Referral and review process.
Initiatives
Quality Improvement Initiatives are identified through analysis of the population demographics, characteristics, high volume, high dollar and problem prone conditions specific and prevalent to a specific population. Potential quality improvement initiatives are identified through routine monitoring by a department or quality improvement committee. Recommendations for initiatives are reviewed and selected for implementation by QIOC, PROFAC and PMT. The selection of activities is based upon the likelihood that a measurable improvement will occur in one of the following: (1) an important clinical outcome; (2) service aspects related to member or provider satisfaction; (3) total healthcare costs (4) patient safety.

Work Plan
In order to meet each program’s annual quality improvement objectives and maintain the mission of this Quality Improvement Plan, a Comprehensive Work Plan has been created. This work plan outlines activities for each program with responsibilities across multiple departments. For each activity a scope, purpose, data type, person(s) accountable, proposed interventions, and reporting schedule are identified. The person or group who is identified as accountable for an activity is responsible for monitoring the progress of the activity toward an identified goal. They are also responsible for reporting progress to the appropriate quality improvement committee according to the schedule.

Quality of Care Program
In the course of their daily responsibilities, the Care Management/Utilization Management Coordinators will screen patient encounters for potential quality of care issues or adverse events. All such occurrences are reported to the Quality Improvement Department for follow up. The information will be reviewed and acted upon as directed by the physician advisors. The results will be tracked in a database to allow for trending.

Quality of Care Complaints: Member complaints regarding quality of care are referred to the Quality Improvement Department for follow up. As above, the information is reviewed and acted upon as directed by physician advisors. The results are tracked and trended along with the Quality of Care Referrals described above.

All results of the Quality of Care Program, unless deemed not to be a quality issue, will be reported to the credentialing committee during the re-credentialing process.

Data Collection and Analysis
Data will be collected from multiple sources. These sources may include, but are not limited to the following: medical record review, administrative claims data, pharmacy claims data, member and provider surveys, customer service reports, complaints and grievance data, and clinical data as submitted by Care Coordinators. Johns Hopkins HealthCare LLC is committed to maintaining excellent data systems and as such pledges support in the collection, management and analysis of data needed for the Quality Improvement Program.

The security, integrity, and confidentiality of all patient information will be maintained according to the corporation’s policies and procedures as well as state and federal regulations. JHHC is compliant with HIPAA regulations and is fully DISCAP accredited.
Analysis of data will be performed using traditional statistical methods including means, modes, median and percentages. An independent vendor will conduct compliance audits, as needed, to ensure a high level of data integrity. Also an independent vendor will conduct the annual member satisfaction survey to assure unbiased results and a venue for members to share their perception on the plan anonymously. This will provide performance data suitable for comparison on national, regional and local levels.

**Quality Improvement Committees**

The Johns Hopkins HealthCare Quality Improvement (JHHC) Committees are designed to address client and consumer requirements and needs. Each committee has distinct responsibilities and the membership includes the appropriate stakeholders and subject matter experts.

**Participating Plan Providers:** JHHC relies on interactions and recommendations from participating plan providers to develop preventive care guidelines, clinical pathways, practice guidelines and action plans for quality improvement initiatives. Feedback from providers is a critical element in the Quality Improvement Program. Therefore, participating providers serve as members of clinical quality improvement committees and clinical QI activities are communicated to providers via newsletters, mailings to individual providers, and group education/communication sessions.

**ENCOUNTER DATA REPORTING REQUIREMENTS**

The Maryland Department of Health and Mental Hygiene (DHMH) requires MCOs to submit data as set forth in the Annotated Code of Maryland 10.09.65.15. An “encounter” is any health care service rendered to an enrolled Medical Assistance recipient by a state contracted MCO or subcontractor to the MCO. The regulations also state that encounter data must be submitted within 60 days after the last day of the month in which the service was rendered.

The encounter data is intended to reflect 100% of the medical services performed as well as the equipment, supplies and tests provided in the medical care of a member. That is, every service rendered to a Medicaid recipient by a provider for the MCO must be reported to DHMH as an encounter record. In addition, any service for which the MCO pays on behalf of the Medicaid recipient (e.g. one for which the recipient has self-referred) must be reported as an encounter. These encounters include, but are not limited to: physician, inpatient, outpatient, long-term care, home health, pharmacy, dental, vision, laboratory, durable medical equipment, disposable medical supplies and other medical practitioner services. The data will be used for:

- Overall program assessment
- Quality Assurance monitoring
- Rate-setting
- Generating Federal and State reports on service utilization
In order for the Maryland DHMH to comply with the State and federal requirements and to perform its necessary quality and financial analyses, it is imperative that encounter data be submitted accurately. It is the provider’s responsibility to submit to Priority Partners encounter or claims data using the national standard 837 electronic format or a clean paper claim using the national standard CMS 1500 form for professional services or the UB-04 form for facility services for each service provided. It is Priority Partners’ responsibility to submit the encounter data to the State within 60 calendar days after receipt of the claim from the provider.

TRANSPORTATION

Priority Partners will provide non-emergency transportation necessary for its members to access a covered service if Priority Partners chooses to provide the service at a location that is outside of the closest county (or Baltimore City) in which the service is available.

To arrange for transportation for a Priority Partners member, contact the Outreach Department at least 48 hours in advance of the scheduled non-urgent medical appointment if possible. Urgent transportation for Priority Partners members who require medical assessment by the PCP due to acute, but non-emergent illness will be handled immediately by the Outreach Department.

Requests for transportation may be made by phone by calling the Outreach Department at 410-424-4648 or by faxing the Physician’s Certificate for Medical Transportation Form to 410-424-4884.

*Providers may contact the LHD to assist members in accessing non-emergency transportation services. The MCO and provider will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD.*
Section III
HEALTHCHOICE BENEFITS AND SERVICES
OVERVIEW

- Priority Partners must provide a complete and comprehensive benefit package that is equivalent to the benefits that are available to Maryland Medicaid recipients through the Medicaid fee-for-service delivery system. Carve-out services (which are not subject to capitation and are not Priority Partners responsibility) are still available for HealthChoice recipients. Medicaid will reimburse these services directly, on a fee-for-service basis.

- A HealthChoice PCP serves as the entry point for access to health care services. The PCP is responsible for providing members with medically necessary covered services, or for referring a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member.

- A member has the right to access certain services without prior referral or authorization by a PCP. This applies to specified self-referred services and emergency services. We are responsible for reimbursing out-of-plan providers who have furnished these services to our members.

- Only benefits and services that are medically necessary are covered.

- HealthChoice members may not be charged any co-payments, premiums or cost sharing of any kind, except for the following:
  - Up to a $3.00 co-payment for brand-name drugs;
  - Up to a $1.00 co-payment for generic drugs;
  - Any other charge up to the fee-for-service limit as approved by the Department.

- We do not impose pharmacy co-payments on the following:
  - Family planning drugs and devices;
  - Individuals under 21 years old;
  - Pregnant women; and
  - Institutionalized individuals who are inpatient in long-term care facilities or other institutions requiring spending all but a minimal amount of income for medical costs.

  Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program.
The pharmacy cannot withhold services even if the recipient cannot pay the co-payment. The recipient’s inability to pay the co-payment does not excuse the debt and they can be billed for the co-payment at a later time. We will not restrict our members’ access to needed drugs and related pharmaceutical products by requiring that members use mail-order pharmacy providers.

MEMBER RIGHTS AND RESPONSIBILITIES

Priority Partners provides our members with a copy of their Rights and Responsibilities in the Priority Partners Member Handbook. The same information is posted on the PPMCO website at www.ppmco.org. A copy of the Rights and Responsibilities follows.

We value you as a member of our health care family. As a member, you have the following rights and responsibilities:

**You have the right to:**
- Be treated with respect to your dignity and privacy.
- Receive information, including information on treatment options and alternatives in a manner you can understand.
- Participate in decision regarding your healthcare, including the right to refuse treatment.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of your medical records and request that they be amended or corrected as allowed.
- Exercise your rights and to know that the exercise of those rights will not adversely affect the way that Priority Partners or our providers treat you.
- File appeals and grievances with us.
- File appeals and grievances with the State.
- State fair hearings.
- Request that ongoing benefits be continued during appeals or State fair hearing. However, you may have to pay for the continued benefits if our decision is upheld in the appeal or hearing.
- Receive a second opinion from another doctor in Priority Partners if you don’t agree with your doctor’s opinion about the services that you need. Contact us at 800-654-9728 for help with this.
- Receive other information about us such as how we are managed. You may request this information by calling 800-654-9728.
- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Make recommendations regarding the organization’s member rights and responsibilities policy.
- Discuss all appropriate treatment options for a condition regardless of cost or benefit coverage.
You have the responsibility to:
- Carry your membership care with you at all times. If you lose your card, call Customer Service to get a new one.
- Cancel doctor’s appointments if you cannot keep them.
- Report any other health insurance coverage to your doctor and Priority Partners.
- Report any communicable diseases, family history, problem with substance abuse and any other information your doctor may need in order to provide adequate care.
- Cooperate with health care providers and follow their instructions.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

COVERED BENEFITS AND SERVICES

Audiology Services for Adults

These services are only covered when it’s part of a hospital stay.

Blood and Blood Products

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

Case management services are covered for members who need such services including, but not limited to, members of special needs populations, which consist of the following non-mutually exclusive populations:

- Children with special health care needs;
- Individuals with a physical disability;
- Individuals with a developmental disability;
- Pregnant and post-partum women;
- Individuals who are homeless;
- Individuals with HIV/AIDS;
- Individuals with a need for substance abuse services; and
- Children in State supervised care.

If warranted, a case manager will be assigned to a member when the results of the initial health screen are received by Priority Partners.

A case manager will perform home visits as necessary as part of the Priority Partners case management program, and will have the ability to respond to a member’s urgent care needs during this home visit.
Dental Services for Children and Pregnant Women

These services are provided by the Maryland Healthy Smiles Dental Program, administered by DentaQuest. Contact them at 888-696-9596 if you have questions about dental benefits.

Diabetes Care Services

Priority Partners covers all medically necessary diabetes care services. We cover diabetes care services for members who have been discharged from a hospital inpatient stay for a diabetes-related diagnosis that include:

- Diabetes nutrition counseling
- Diabetes outpatient education
- Diabetes-related durable medical equipment and disposable medical supplies, including:
  - Blood glucose meters for home use;
  - Finger sticking devices for blood sampling;
  - Blood glucose monitoring supplies; and
  - Diagnostic reagent strips and tablets used for testing for ketone and glucose in urine and glucose in blood.

- Therapeutic footwear and related services to prevent or delay amputation that would be highly probable in the absence of specialized footwear.

Dialysis Services

Members in HealthChoice who suffer from End Stage Renal Disease (ESRD) are eligible for REM. To be REM-eligible on the basis of ESRD, members must meet one of the following sets of criteria:

- Children (under 21 years old) with chronic renal failure (ICD-9 code 585.1-585.6) diagnosed by a pediatric nephrologist; and

- Adults (ages 21-64) with chronic renal failure with dialysis (ICD-9 code 585.6, V45.11 and 585.9).

For those members needing dialysis treatment who are enrolled in Priority Partners, dialysis services are covered, either through participating providers or, at the member’s option, non-participating providers.
DMS/DME

- Authorization for DME and/or DMS will be provided in 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 7 calendar days from the date of the initial request.

- Disposable medical supplies are covered, including incontinency pants and disposable underpants for medical conditions associated with prolonged urinary or bowel incontinence, if necessary to prevent institutionalization or infection, and all supplies used in the administration or monitoring of prescriptions by the member.

- Durable medical equipment is covered when medically necessary including but not limited to all equipment used in the administration or monitoring of prescriptions by the Member. We 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 Priority Partners as long as the member remains Medicaid eligible during the 90-day time period.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

For members under 21 years of age, all of the following EPSDT services are covered:

- Well-child services provided in accordance with the EPSDT 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 dental screening; and
  - Health education.

- EPSDT partial or interperiodic well-child services and health care services necessary to prevent, treat, or ameliorate physical, mental, or developmental problems or conditions, which services are sufficient in amount, duration, and scope to treat the identified condition, and are subject to limitation only on the basis of medical necessity, including:
  - Chiropractic services;
  - Nutrition counseling;
  - Audiological screening when performed by a PCP;
  - Private duty nursing;
  - Durable medical equipment including assistive devices; and
  - Any other benefit listed in this section.
Providers are responsible for making appropriate referrals for publicly funded programs not covered by Medicaid, including Head Start, the WIC nutritional program, early intervention services; School Health-Related Special Education Services, vocational rehabilitation, and Maternal and Child Health Services (located at local health departments).

**Family Planning Services**

Comprehensive family planning services are covered, including:

- Office visits for family planning services;
- Laboratory tests including pap smears;
- Contraceptive devices; and
- Voluntary sterilization.

**Home Health Services**

Home health services are covered when the member’s PCP or attending physician certifies that the services are necessary on a part-time, intermittent basis by a member who is homebound and 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 second visit);
- Physical therapy services;
- Occupational therapy services;
- Speech pathology services; and
- Medical supplies used in a home health visit.

**Hospice Care Services**

Hospice care services are covered for members who are terminally ill with a life expectancy of six months or less. Hospice services can be provided in a hospice facility, in a long-term care facility, or at home.

Hospice providers should inform their Medicaid members (or members applying for Medicaid coverage) as soon as possible after they enter hospice care about the MCOs with whom they contract so that members can make an informed choice.
We do not require a hospice care member to change his/her out of network hospice provider to an in-network hospice provider. Hospice providers should make members aware of the option to change MCOs. DHMH will allow new members who are in hospice care to voluntarily change their MCO if they have been auto-assigned to a MCO with whom the hospice provider does not contract. If the new member does not change their MCO, then the MCO, which the new member is currently enrolled must pay the out-of-network hospice provider.

**Inpatient Hospital Services**

Inpatient hospital services are covered.

For special rules for length of stay for childbirth (See page 25).

**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 directly by the Department and must be rendered by a Department approved provider and be medically necessary.

**Long-term Care Facility Services/Nursing Facility Services**

Long-term care facilities include chronic hospitals, chronic rehabilitation hospitals, and nursing facilities. The first 30 days in a long-term care facility are the responsibility of Priority Partners, subject to specific rules.

When a member is transferred to a long-term care facility and the length of the member’s stay is expected to exceed 30 days, medical eligibility approval of the Department of Health and Mental Hygiene (DHMH) for long-term institutionalization must be secured as soon as possible.

We cover the first 30 days or until DHMH medical eligibility approval is obtained, whichever is longer. If required disenrollment procedures are not followed, our financial responsibility continues until the State’s requirements for the member’s disenrollment are satisfied. In order for a member to be disenrolled from Priority Partners based on a long-term care facility admission, all of the following must first occur:

- An application, DHMH 3871, for a Departmental determination of medical necessity must be filed. *(If a length of stay of more than 30 days is anticipated at the time of admission, the application should be filed at the time of admission).*

  DHMH must determine that the member’s long-term care facility admission was medically necessary in accordance with the State’s criteria.
- The member’s length of stay must exceed 30 consecutive days.

- We must file an application for disenrollment with DHMH, including documentation of the member’s medical and utilization history, if requested.

Once an individual has been disenrolled from Priority Partners, the services they receive in a qualifying long-term care facility will be directly reimbursed by the Maryland Medical Assistance program, as long as the recipient maintains continued eligibility.

Inpatient acute care services provided within the first 30 days following admission to a long-term care facility are not considered an interruption of Priority Partners covered 30 continuous days in a long term care facility as long as the member is discharged from the hospital back to the long term care facility.

An individual with serious mental illness, or mental retardation or a related condition may not be admitted to a nursing facility unless the State determines that nursing facility services are appropriate. For each member seeking nursing facility admission, a Pre-admission Screening and Resident Review (PASRR) ID Screen must be completed.

The first section of the ID Screen exempts a member if NF admission is directly from a hospital for the condition treated in the hospital and, the attending physician certifies prior to admission to the NF that the recipient is likely to require less than 30 days of NF services.

If a member is not exempted, complete the ID Screen to identify whether the member screens positive for mental illness or mental retardation. If the member screens negative, refer to Adult Evaluation and Review Services (AERS) located in the local health department for a STEPS assessment to help identify alternative services to NF placement.

If a member is admitted into an Institution for Mental Disease (IMD), we are responsible for a member’s somatic care during the first 30 consecutive days after admission, and during stays of less than 30 days, with an overall limit of a total of 60 days per calendar year, regardless of consecutiveness. Our responsibility for a member’s somatic care would continue beyond 30 consecutive days if the member is not disenrolled from the MCO.

A member admitted to an Intermediate Care Facility - Mental Retardation (ICF-MR) is disenrolled from Priority Partners immediately upon admission to the facility, and we retain no responsibility for the member’s care.

If we place a member in a licensed nursing facility that is not a Maryland Medical Assistance Program provider, Medicaid cannot pay the facility for services. Upon MCO disenrollment, the patient may transfer to a nursing home that accepts Medicaid payment.

If a member under age 21 is admitted into an ICF-A, we are responsible for medically necessary treatment for as many days as required.
We will reserve nursing facility beds for recipients hospitalized for an acute condition within the first three days not to exceed 15 days per single acute visit.

**Outpatient Hospital Services**

Medically necessary outpatient hospital services are covered.

**Oxygen and Related Respiratory Equipment**

Oxygen and related respiratory equipment are covered.

**Pharmacy Services**

We will expand our drug formulary to include new products approved by the Food and Drug Administration (COMAR 10.09.67.04D(3)) in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high risk and special needs populations and vaccines prescribed to protect individuals against vaccine-preventable diseases. If a generic equivalent drug is not available, new brand name drug rated as P (priority) by the FDA will be added to the formulary. Coverage may be subject to preauthorization to ensure medical necessity for specific therapies. For formulary drugs requiring preauthorization, a decision will be provided in a timely manner so as not to adversely affect the member’s health and within two business days of receipt of necessary clinical information but not later than seven calendar days from the date of the initial request. If the service is denied, Priority Partners will notify the prescriber and the member in writing of the denial (COMAR 10.09.71.04).

When a prescriber believes that a non-formulary drug is medically indicated, we have procedures in place for non-formulary requests (COMAR 10.09.67.04F(2)(a)). 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;
- Contraceptives;
- Latex condoms (to be provided without any requirement for a provider’s order);
- Non-legend ergocalciferol liquid (Vitamin D)
- Hypodermic needles and syringes;
• Enteral nutritional and supplemental vitamins and mineral products given in the home by nasogastric, jejunostomy, or gastrostomy tube;

• Enteric coated aspirin prescribed for treatment of arthritic conditions;

• Non-legend ferrous sulfate oral preparations;

• Non-legend chewable ferrous salt tablets when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in formulation, for members under age 12;

• Formulas for genetic abnormalities;

• Medical supplies for compounding prescriptions for home intravenous therapy;

• Medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider.

• Most Mental health drugs are on SMHS formulary and are to be paid by SMHS.

• Most HIV/AIDS drugs are paid directly by the State.

Priority Partners drug utilization review program is subject to review and approval by DHMH, and is coordinated with the drug utilization review program of the SMHS delivery system.

Limitations: neither the State nor the MCO cover the following:

• Prescriptions or injections for central nervous system stimulants and anorectic agents when used for controlling weight; or

• Non-legend drugs other than insulin and enteric aspirin ordered for treatment of an arthritic condition.
Physician and Advanced Practice Nurse 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; and
- Services provided in a clinic by or under the direction of a physician or dentist; and
- Services performed by a dentist or dental surgeon, when the services are customarily performed by physicians.

Priority Partners shall clearly define and specify referral requirements to all providers.

A member’s PCP is responsible for making the determination, based on our referral requirements, of whether or not a specialty care referral is medically necessary.

- PCPs must follow our special referral protocol for children with special healthcare needs who suffer from a moderate to severe chronic health condition which:
  - Has significant potential or actual impact on health and ability to function;
  - Requires special health care services; and
  - Is expected to last longer than 6 months.
- A child who is functioning one third 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 affect a permanent cure.

Podiatry Services

Priority Partners provides its members medically necessary podiatry services as follows:

- For all members medically necessary podiatry services
- Diabetes care services specified in COMAR 10.09.67.24
- Routine foot care for members 21 years old or older with vascular disease affecting the lower extremities and for members with diabetes.

Primary Care Services

Primary care is generally received through a member’s PCP, who acts as a coordinator of care, and has the responsibility to provide accessible, comprehensive, and coordinated health care services covering the full range of benefits for which a member is eligible. In some
cases, members will opt to access certain primary care services by self-referral to providers other than their PCPs, for example, school-based health centers. Primary care services include:

- Addressing the member’s general health needs;
- Coordination of the member’s health care;
- Disease prevention and promotion and maintenance of health;
- Treatment of illness;
- Maintenance of the members’ health records; and
- Referral for specialty care.

For Female Members: If the member’s PCP is not a women’s health specialist she may see a women’s health specialist within Priority Partners without a referral, for covered services necessary to provide women’s routine and preventive health care services

**Primary Mental Health Services**

We cover primary mental health services required by members, including clinical evaluation and assessment, provision of primary mental health services, and/or referral for additional services, as appropriate.

The PCP of a member requiring mental health services may elect to treat the Member, if the treatment falls within the scope of the PCP’s practice, training, and expertise. Neither the PCP nor Priority Partners may bill the Public Mental Health System (PMHS) for the provision of such services because these services are included in the HealthChoice capitation rates.

When, in the PCP’s judgment, a member’s need for mental health treatment cannot be adequately addressed by primary mental health services provided by the PCP, the PCP should, after determining the member’s eligibility (based on probable diagnosis), refer the Member to the SMHS for specialty mental health services. (Process is described in Section IV).

**Rehabilitative Services**

Rehabilitative services including medically necessary physical therapy, speech therapy, and occupational therapy for adults are covered. For members under 21, rehabilitative services are covered by Priority Partners only if it’s a part of a home health visit or inpatient hospital stay. All other rehabilitative services for members under 21 should be billed fee-for-service to the Department.

**Second Opinions**

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

Substance abuse treatment services are covered.

Transplants

Medically necessary transplants are covered.

Vision Care Services

Medically necessary vision care services are covered.

Priority Partners is responsible to provide at a minimum:

- One eye examination every 2 years for members age 21 or older; or

- For members under 21, at least one eye examination every year in addition to EPSDT screening, one pair of eyeglasses per year unless lost, stolen, broken, or no longer vision appropriate, and contact lenses, if eyeglasses are not medically appropriate for the condition.

Benefit Limitations

The following are not covered under HealthChoice:

- Services that are not medically necessary.

- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state).

- Services that are beyond the scope of practice of the health care practitioner performing the service.

- Abortions. (Available under limited circumstances through Medicaid fee-for-service.)

- Autopsies.

- 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.

- Services provided outside the United States.
• Dental services for adults Is limited to cleaning and x-rays every 6 months, and simple extractions

• Diet and exercise programs for weight loss except when medically necessary.

• Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when a member is participating in an authorized clinical trial as specified in COMAR 10.09.67.26-1.

• Immunizations for travel outside the U.S.

• 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 procedures.

• Lifestyle improvements (physical fitness programs, nutrition counseling, smoking cessation) unless specifically included as a covered service.

• Medication for the treatment of sexual dysfunction.

• Non-legend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the member is younger than 12 years old.

• 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.

• Orthodontia except 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.

• Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis.

• Private duty nursing for adults 21 years old and older.

• Private hospital room unless medically necessary or no other room available.

• Purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, other than for members younger than 21 years old.

• Reversal of voluntary sterilization procedure.

• Services performed before the effective date of the member’s coverage.
- Therapeutic footwear other than for a member who qualifies for diabetes care services or for a member who is younger than 21 years old.

- Priority Partners will assist members to secure non-emergency transportation services through Local Health Departments (LHDs). Additionally, we will provide non-emergency transportation to access a covered service if we choose to provide the service at a location that is outside of the closest county in which the service is available. The following is a list of the transportation contact numbers for each county:

<table>
<thead>
<tr>
<th>County</th>
<th>Company</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alleghany</td>
<td>Van Trans Inc.</td>
<td>301-722-2770</td>
</tr>
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<td></td>
<td>Alleghany Ambulance</td>
<td>301-689-1113</td>
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<tr>
<td>Anne Arundel</td>
<td>AAA Transport</td>
<td>800-442-2858</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>New Clients</td>
<td>410-396-7007</td>
</tr>
<tr>
<td></td>
<td>Established Clients</td>
<td>410-396-6422</td>
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<tr>
<td></td>
<td>(Facilities only)</td>
<td>410-396-6665</td>
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<tr>
<td>Baltimore County</td>
<td>Veolia Transportation</td>
<td>410-783-2465</td>
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<td></td>
<td>410-887-2828</td>
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<tr>
<td>Calvert</td>
<td>AAA Transport</td>
<td>800-577-1050</td>
</tr>
<tr>
<td>Caroline</td>
<td>Bay Area Transportation</td>
<td>800-987-9088</td>
</tr>
<tr>
<td></td>
<td>Best Care Ambulance</td>
<td>410-476-3688</td>
</tr>
<tr>
<td>Carroll</td>
<td>Butler Medical Transport</td>
<td>888-602-4007</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Cecil</td>
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<tr>
<td>Charles</td>
<td></td>
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<tr>
<td>Dorchester</td>
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<tr>
<td>Frederick</td>
<td></td>
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<tr>
<td>Garrett</td>
<td>Garrett Community Action</td>
<td>301-334-9431</td>
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<tr>
<td>Harford</td>
<td></td>
<td>410-638-1671</td>
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</table>
Howard  AAA Transport  800-577-1050
Kent  410-778-7025
Montgomery  Department of Public Works and Transit  240-777-5899
Prince George’s  301-856-9555
Queen Anne’s  Department of Aging  410-758-2357
St. Mary’s  301-475-4296
Somerset  Shore Transit  443-260-2300
Lifestar  410-546-0809
Talbot  Bay Area Transportation  800-987-9008
Best Care ambulance  410-476-3688
Washington  240-313-3264
Wicomico  Shore Transit  443-260-2300
Lifestar  410-546-0809
Worcester  410-632-0092 or 410-632-0093

Medicaid Covered Services Not the Responsibility of Priority Partners

The following services are paid by the State on a fee-for-service basis.

- Occupational therapy, Physical therapy, Speech therapy or Audiology services, including hearing aids for children under the age of 21 years.

- Intermediate care facilities - mental retardation services are available through State facilities.

- Medical day care services are available through direct provider reimbursement by the State on a fee-for-service basis.

- Personal care services are available through direct provider reimbursement by the State on a fee-for-service basis.

- Viral load, genotypic, phenotypic or HIV/AIDS drug resistance testing, and enfuvirtide used in treatment of HIV/AIDS are reimbursed directly by the Department if service is
rendered by a Department approved provider and medically necessary.

- Specialty mental health services.

- All services to individuals enrolled in the Rare and Expensive Case Management Program.

- Service provided after the thirtieth day of a member’s admission in a chronic hospital, rehabilitation hospital, skilled nursing facility, intermediate care facility or Institution for Mental Disease. The 30 day limit is subject to Priority Partners receiving the Departments approval for disenrollment from our MCO.

- Health-related services and targeted case management services provided to children when the services are specified in the child’s Individualized Family Service Plan or Individualized Education Plan and provided in the schools or by community-based children’s medical services providers.

- Healthy Start Case Management Services delivered by Local Health Departments.

- Special support services for individuals covered under the Developmental Disabilities waiver.

- Antiretroviral drugs in American Hospital Formulary Service therapeutic class 8:18:08 used in the treatment of HIV/AIDS.

**Self-Referral Services**

Members can elect to receive certain covered services from out-of-plan providers. Priority Partners will cover these pursuant to COMAR 10.09.67.28. The services that a member has the right to access on a self-referral basis include:

- Certain family planning services including office visits, diaphragm fitting, IUD insertion and removal, special contraceptive supplies, Norplant removal, depo-provera-FP, latex condoms, and PAP smear;

- Certain school-based health center services including diagnosis and treatment of illness or injury that can be effectively managed in a primary care setting, well child care and the family planning services listed above;

- Initial medical examination for a child in State-supervised care

- Unless Priority Partners provides for the service before a newborn is discharged from the hospital, the initial examination of a newborn before discharge, if performed by an out-of-network on-call hospital provider

- Annual Diagnostic and Evaluation Service (DES) visit for a member diagnosed with HIV or AIDS
• Continued obstetric care with her pre-established provider for a new pregnant member and

• Renal dialysis services;

• Pharmaceutical and laboratory services, when provided in connection with a legitimately self-referred service, provided on-site by the same out-of-plan provider at the same location as the self-referred service.

• A newly enrolled child with a special health care need may continue to receive medical services directly related to the child’s medical condition under a plan of care that was active at the time of the child’s initial enrollment, if the child’s out-of-plan provider submits the plan of care to Priority Partners for review and approval within 30 days of enrollment.

• Emergency services as described in COMAR 10.09.66.08 B.

• Substance abuse services such as individual and group counseling, detoxification and inpatient care when provided by an ADAA certified provider and ASAM criteria is met.

• A comprehensive substance abuse assessment (CSAA) if the following conditions are met:
  • Recipient is not currently in substance abuse treatment.
  • Recipient has not had a CSAA during the same calendar year, and
  • The assessment provider is an ADAA certified substance abuse provider who is qualified to administer the ASI or POSIT, and the ASAM.

CREDENTIALING AND RE-CREDENTIALING

The JHHC Credentialing Process is an important component of the JHHC Quality Assurance Program. JHHC’s Credentialing process is reviewed, at a minimum, annually by the Special Credentials Review Committee, JHHC’s credentialing governing body.

The goal of credentialing is to ensure that JHHC has a qualified multidisciplinary practitioner panel to deliver safe, effective and appropriate care to its members. At the time of initial credentialing and prior to issuing approval all provider candidate applications undergo the following primary source verifications:

- Licensure
- Education
- National Practitioner (NPDB) and Healthcare Integrity and Protection (HIPDB) Databanks
- Criminal background check (USIS)
- Office of Inspector General
- Board Certification (if applicable)
- Hospital Affiliation
Practitioners are re-credentialed on at least an every three-year cycle. Therefore, practitioners credentialed on or before July 1, 2008 must be re-credentialed on or before June 30, 2011. In order to facilitate timely re-credentialing, 120 days prior to the practitioner’s expiration date, JHHC’s Credentialing Department will mail out a blank current State of Maryland Uniform Credentialing Form (UCF) to the provider. For your convenience this state mandated form can also be found on the JHHC website (https://www.jhhc.com/mcnet/).

Practitioners are required to:

- Submit either a completed current copy of the State of Maryland Uniform Credentialing Form (UCF) or a current downloaded CAQH application
- Correct and/or update any necessary information,
- Attach the required documentation
- Ensure that all information is up-to-date and accurate before signing the authorization for release of information (page 18)
- Return it in the envelope provided within fifteen days of receipt.

Continued network participation is dependent upon completion of the re-credentialing process within the established timeframe. Please contact your Provider Relations Network Manager at 410-762-5385 or 888-895-4998 or the Credentialing Department at 410-424-4619 if you have questions about the credentialing process.

**Termination of Participation**

Provider Agreements may be terminated by JHHC, effective immediately “For Cause”. Examples of “for cause” may be defined as but not limited to:

- Fraud
- Patient abuse
- Incompetence
- Loss of licensure
- Loss of participation status in State or Federal Payor Programs (Medicare, Medicaid).

**Contractual Terminations**

Either the provider or JHHC may terminate the Provider Agreement with written notice to the non-terminating party at least 90 days prior to the termination date. The provider will continue to provide or arrange for services to members prior to the effective date of termination and following termination to any member whose medical condition requires a continuing course of treatment where alternative arrangements have not been made. Upon receipt of a voluntary termination from a practitioner or practice group and the defined criteria for notification is met, Johns Hopkins HealthCare (JHHC) will notify members affected by the termination of a practitioner or practice group in general, family, internal medicine or pediatrics, and other defined specialists, at least thirty (30) calendar days prior to the effective termination date or within thirty (30) calendar days of notification from the practitioner, and assists them in selecting a new practitioner.
Transition of Care upon Provider Termination

The JHHC provider agreement requires all providers to give at least 90 days advance notice of contract termination. JHHC notifies members affected by the termination of a primary care practitioner or practice group at least thirty (30) calendar days prior to the effective termination date or within thirty (30) calendar days of notification from the practitioner, and assist them in selecting a new practitioner.

In some cases members may be able to continue care with a terminated practitioner for a short period of time after the practitioner leaves the network. If this situation applies, JHHC will discuss this with you at the time of your termination.

More information about your obligations upon contract termination is located in your provider agreement. If you have additional questions, please contact Provider Relations at 410-762-5385 or 888-895-4998.

Rights to Appeal Termination

No appeal rights are available if there is a:
- Revocation of license,
- Conviction of fraud, or
- Initial credentialing is denied

Providers, who are eligible for appeal, must submit their request in writing within 30 calendar days of their original termination. The Chief Medical Director will convene an appeal panel comprised of three qualified practitioners. At least one practitioner is a clinical peer of the appealing provider who is not otherwise involved in JHHC network management operations activities. For the purpose of this requirement, a clinical peer is a provider with the same type of license. The panel shall not include any individual who is in direct economic competition with the affected provider or who is professionally associated with or related to the provider or who otherwise might directly benefit from the outcome. Knowledge of the matter shall not preclude any individual from serving as a member of the panel; however, involvement with any earlier decision concerning the initial determination or corrective action will require the individual to remove him/herself from the panel.

Within ten (10) calendar days of either a first or second level panel review and after reviewing any written statements submitted by the provider and any other relevant information, the panel will render a decision. The Chief Medical Director or designee will notify the affected provider in writing within five calendar days of the panel’s decision. This notice will be sent either by certified mail return receipt requested or FedEx.

If the provider requests a second review, the provider is subject to the following:
- There is no right to personal appearance before the panel;
- The burden of proof remains with provider to explain their actions or lack of actions;
- The provider may submit a written statement for the panel’s consideration;
- The provider may submit the written statements of others for the panel’s consideration;
- The provider may submit other documents relevant to the determination; and
- A determination by the Second Level Review Panel is final with no further appeal rights.
Section IV
SPECIALITY MENTAL HEALTH SERVICES
INTRODUCTION

Under the HealthChoice program we are responsible for a comprehensive package of services, with limited exceptions detailed in Section III. The HealthChoice program, however, has two significant program areas where eligible recipient’s services are not the responsibility of the MCO. These ‘carve outs’ are distinct in that one carves out a service, specialty mental health care, and the other carves out a population, individuals who qualify for the Rare and Expensive Case Management (REM program).

Specialty Mental Health Services (SMHS)
www.dhmh.state.md.us/mha

Description

In the State of Maryland, the system responsible for the delivering of specialty mental health services to Medicaid recipients is the Public Mental Health System (PMHS). The PMHS will deliver all specialty mental health services to members in HealthChoice. The Mental Hygiene Administration (MHA), in collaboration with Core Service Agencies (CSA) operate the PMHS. The MHA contracts with an Administrative Service Organization (ASO) to provide administrative management functions for all the PMHS, Statewide.

Local Access to SMHS - Role of the Core Services Agencies (CSAs)
www.dhmh.state.us/mha/csa.overview

Twenty CSAs serve as the local entities in charge of the mental health service delivery system in their jurisdictions. Working in conjunction with the MHA, CSAs:

- Plan, establish, coordinate and manage publicly funded mental health services in their respective jurisdictions. CSAs will promote the full participation of mental health recipients, family members, caregivers, local human service and healthcare agencies, as well as other appropriate stakeholders in developing and evaluating these services.

- Determine type and capacity need of providers to offer a comprehensive array of publicly funded mental health services for their communities.

- Assure recipient access to services.

- Measure the quality of the services rendered.

- Handle grievances and appeals, in accordance with COMAR 10.09.71.03
Role of the Administrative Service Organization (ASO)

The ASO:

- Verifies the eligibility of recipients.
- Authorizes services that are determined to be medically necessary according to criteria set by the MHA.
- Refers individuals to qualified providers of public mental health services.
- Performs service utilization review to assess quality, appropriateness and effectiveness of care for the MHA in collaboration with the CSAs.
- Processes billing claims and remits payments.
- Maintains 24-hour, toll free telephone access seven days a week for recipients at 800-888-1965. Access for providers is maintained from 8:00 am to 6:00 pm Monday through Friday at 800-888-1965.
- Conducts annual provider and recipient satisfaction surveys and submits results to the MHA and the CSAs.

Access to Specialty Mental Health Services

- Specialty mental health services (i.e., any mental health services other than primary mental health services) are not subject to capitation and are not our responsibility. Even so, Priority Partners or our PCPs do have the responsibility to refer eligible members to the PMHS when specialty mental health services are needed.
- A member with a probable diagnosis of a mental disorder is eligible for referral to the SMHS by the PCP or Priority Partners if the following conditions are met:
  - The member’s probable diagnosis of a mental disorder was established in accordance with the current American Psychiatric Association Diagnostic and Statistical Manual recognized by DHMH;
  - The probable diagnosis is not a sole diagnosis of substance abuse or dependence, dementia, or mental retardation or one of the diagnoses listed at the end of this section; and
  - The PCP or Priority Partners determines that primary mental health services provided by the PCP are insufficient to address the member’s mental health treatment needs.
• A mental health professional functioning as the SMHS utilization review (UR) agent will accept pre-authorization requests to determine the medical necessity for mental health assessment or treatment. The SMHS UR agent will preauthorize medically necessary services of a type, frequency, and duration that are consistent with expected results and are cost-effective.

• If the SMHS UR agent determines that there is medical necessity for specialty mental health services, the member will be linked with the appropriate services.

• If the SMHS UR agent determines that specialty mental health services are not medically necessary, the SMHS UR will, as appropriate, promptly consult the referral source for assistance in developing a plan for the member, to determine whether an alternative service or a service of alternate duration is appropriate.

• If the SMHS UR agent denies services, the member and the provider are notified in writing, specifying the clinical rationale for the denial, and outlining procedures for appealing the denial.

• With the recipient’s permission, the treating mental health provider communicates directly with the PCP to coordinate mental health and somatic care.

• The SMHS UR agent may not deny services without arranging an appropriate alternative service if the denial of services would abruptly change the member’s living situation or cause severe disruption to a member with serious and persistent mental illness or serious emotional disturbance.

Referring a member to the SMHS through a Toll Free Help Line: 800-888-1965

The ASO’s toll free number is available 24 hours a day, seven days a week and is staffed by qualified mental health professional called Care Managers.

Members are able to access the ASO directly or through assistance from Priority Partners, their PCP, a mental health provider, family member or caregiver. Staff is trained to handle those who are non-English speaking or hearing impaired. Back up physician advisors will be available at all times.

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

• **Acute Crisis** - A situation in which an individual is threatening imminent harm to their self or others. The member or the person making the call may state or imply that the recipient is not in control of these impulses. Help will be dispatched immediately, while keeping the caller on the line with a clinician.

• **Emergency** - A situation involving a member or the person making the call who states or implies that the recipient may do harm to their self or others if help is not received soon.
The caller states or implies the recipient’s need for help, but may be able to maintain impulse control for several hours until help can be arranged. The Care Manager’s assessment of the situation presented is that acute crisis services would not be needed. In these cases, the PMHS protocols require that authorizations be made within one hour and face-to-face emergency services must be provided within four hours.

- **Urgent** - A situation in which the recipient is experiencing a decrease in self-control and increasing frustration over life events. The Care Manager's assessment is that neither acute crisis nor emergency services are needed. As a result, the member plans or engages in avoidance activities, such as running away, rather than threatening harm to self or others. The PMHS protocols require that an urgent situation be handled through face-to-face services within 24 hours.

- **Scheduled** - A situation in which the member or caller feels that the member is in no immediate harm, but requires an assessment and, probably mental health services. The PMHS protocols require that recipients be seen by a provider within 10 working days.

- The PMHS will arrange for medically appropriate psychiatric consultations for any condition.

**Specialty Mental Health Diagnoses Covered by the PMHS**

295.00 – 298.9
299.9
300.00 – 301.6
301.81 – 302.6
302.81 – 302.9
307.1
307.3
307.5 – 307.89
308.0 – 308.9
309.0 - 309.9
311
312.0 – 312.9
313.0 – 312.9
313.0 - 313.82
313.89 – 314.9
332.1
333.1
333.82
333.90
333.92
333.99
Section V
RARE AND EXPENSIVE CASE MANAGEMENT (REM) PROGRAM
RARE AND EXPENSIVE CASE MANAGEMENT (REM) PROGRAM

Overview

The Department of Health and Mental Hygiene (DHMH) administers a Rare and Expensive Case Management (REM) program to address the special needs of waiver-eligible individuals diagnosed with rare and expensive medical conditions. The REM program, a part of the HealthChoice Program, was developed to ensure that individuals who meet specific criteria receive high quality, medically necessary and timely access to health services.

Qualifying diagnoses for inclusion in the REM program must meet the following criteria:

- Occurrence is generally fewer than 300 individuals per year;
- Cost is generally more than $10,000 on average per year;
- Need is for highly specialized and/or multiple providers/delivery system;
- Chronic condition;
- Increased need for continuity of care; and
- Complex medical, habilitative and rehabilitative needs.

Medicaid Services and Benefits

To qualify for the REM program, a recipient must have one or more of the diagnoses specified in the Rare and Expensive Disease List at the end of this section. The recipients may elect to enroll in the REM Program, or to remain in Priority Partners if the Department agrees that it is medically appropriate. REM participants are eligible for fee-for-service benefits currently offered to Medicaid-eligible recipients not enrolled in MCOs as well as additional, optional services, which are described in COMAR 10.09.69. All certified Medicaid providers other than HMOs, MCOs, ICF-MRs and IMDs are available to REM participants, in accordance with the individual’s plan of care.

Case Management Services

In addition to the standard and optional Medicaid services, REM participants have a case manager assigned to them. The case manager’s responsibilities include:

- Gathering all relevant information needed to complete a comprehensive needs assessment;
- Assisting the participant with selecting an appropriate PCP, if needed;
- Consulting with a multi-disciplinary team that includes providers, participants, and family/care givers, to develop the participant’s plan of care;
- Implementing the plan of care, monitoring service delivery, and making modifications to the plan as warranted by changes in the participant’s condition;
• Documenting findings and maintaining clear and concise records;

• Assisting in the participant’s transfer out of the REM program, when and if appropriate.

**Care Coordination**

REM case managers are also expected to coordinate care and services from other programs and/or agencies to ensure a comprehensive approach to REM case management services. Examples of these agencies and programs are:

• DHMH - Healthy Start Program - follow up newborn assessments;

• Developmental Disability Administration - coordinate services for those also in the Home and Community-based Services Waiver;

• DHMH - Maternal Child Health Division on EPSDT - guidelines and benchmarks and other special needs children’s issues;

• AIDS Administration - consult on pediatric AIDS;

• DHR - coordinate Medical Assistance eligibility issues; coordinate/consult with Child Protective Services and Adult Protective Services; coordinate with foster care programs;

• Department of Education - coordination with the service coordinators of Infants and Toddlers Program and other special education programs;

• Mental Hygiene Administration - referral for mental health services to the Specialty Mental Health System, as appropriate, and coordination of these services with somatic care.

**Referral and Enrollment Process**

Candidates for REM are generally referred from HealthChoice MCOs, providers, or other community sources. Self-referral or family-referral is also acceptable. 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 recipient’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 recipient and referral source.

If the Intake nurse determines that the recipient has a REM-qualifying diagnosis, the nurse approves the recipient for enrollment. However, before actual enrollment is completed, the Intake Unit contacts the PCP to see if he/she will continue providing services in the fee-for-service environment. If not, the case is referred to a case manager to arrange a PCP in consultation with the recipient.
If the PCP will continue providing services, the Intake Unit then calls the recipient to notify of the enrollment approval, briefly explain the program, and give the recipient an opportunity to refuse REM enrollment. If enrollment is refused, the member remains in the MCO. At the time of recipient notification, The Intake Unit also ascertains if the recipient is receiving services in the home, e.g., home nursing, therapies, supplies, equipment, etc. If so, the case is referred to a case manager for service coordination.

We are responsible for providing the recipient’s care until the recipient is actually enrolled in the REM program. If the recipient does not meet the REM criteria, the recipient will remain enrolled in Priority Partners.

For questions or to request a REM Referral Form, please call 800-565-8190. Referrals may be faxed to the REM Intake Unit at 410-333-5426 or mailed to the following address:

REM Program Intake Unit  
Maryland Department of Health and Mental Hygiene  
Office of Health Services  
201 W. Preston Street, Room 210  
Baltimore, MD 21201-2399
# Table of Rare and Expensive Disease List as of July 2008

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<th>ICD-9</th>
<th>Disease</th>
<th>Age Group</th>
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<tbody>
<tr>
<td>042</td>
<td>Symptomatic HIV disease/AIDS (pediatric)</td>
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<td>V08</td>
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<td>795.71</td>
<td>Infant with inconclusive HIV result</td>
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<td>270.0</td>
<td>Disturbances of amino-acid transport:</td>
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<tr>
<td></td>
<td>Cystinosis</td>
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<tr>
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<td>Phenylketonuria – PKU</td>
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<td>Other disturbances of aromatic-acid metabolism</td>
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<td>Disturbances of branched-chain amino-acid metabolism</td>
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<td>Glucoglycinuria</td>
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<td>Glycinemia (with methylmalonic acidemia)</td>
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<td>Hyperglycinemia, Hyperlysinemia</td>
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<td>Saccharopinuria</td>
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<tr>
<td></td>
<td>Other disturbances of metabolism of glycine, threonine, serine, glutamine, and lysine</td>
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<td>Disease</td>
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<td>Other specified disorders of amino-acid metabolism:</td>
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Section VI
DHMH QUALITY IMPROVEMENT AND MCO OVERSIGHT
QUALITY ASSURANCE MONITORING PLAN

The quality assurance monitoring plan for the HealthChoice program is based upon the philosophy that the delivery of health care services, both clinical and administrative, is a process that can be continuously improved. The State of Maryland’s quality assurance plan structure and function supports efforts to deal efficiently and effectively with any identified quality issue. On a daily basis and through a systematic process of annual audit of MCO operations and health care delivery, the Department identifies both positive and negative trends in service delivery. Quality monitoring and evaluation and education through member and provider feedback is an integral part of the managed care process and helps 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, outcomes measures and data reporting activities.

The Department has adopted a variety of methods and data reporting activities to assess MCO service quality to Medicaid members. These areas include:

- Health Risk Assessment screening conducted by the enrollment broker at the time the recipient selects an MCO to assure that the MCO is alerted to immediate health needs, e.g., prenatal care service needs.

- A complaint process administered by Department staff.

- A complaint process administered by Priority Partners.

- A review of each MCO’s quality improvement processes and clinical care through an annual systems performance review 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.

- The annual collection, validation and evaluation of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a set of standardized performance measures designed by the National Committee for Quality Assurance. The measures are audited by an independent entity and results are reported to DHMH.

- The annual collection and evaluation of a set of performance measures identified by the Department.

- An annual member satisfaction survey using the Consumer Assessment of Health Plans Survey (CAHPS).
• Monitoring of preventive health, access and quality of care outcome measures based on encounter data.

• Development and implementation of HealthChoice outreach plan.

• A review of services to children to determine our compliance with federally required EPSDT standards of care.

• The annual production of a Consumer Report Card.

**Quarterly Complaint Reporting**

We are responsible for gathering and reporting to the State information about member’s appeals and grievances and our interventions and resolution to these appeals and grievances. The reports contain data on appeals and grievances in a standardized format and are submitted on a quarterly basis. To accomplish this, we are required to operate a Consumer Services Hotline and Internal complaint process.

**Priority Partners Member Hotline**

Priority Partners maintains a member services unit that operates a member services hotline (Monday-Friday, 8 a.m. to 5 p.m.). This unit handles and resolves or properly refers members' inquiries or complaints to other agencies. Additionally, we provide members with information about how to access our member services unit and consumer services hotline to obtain information and assistance.

**Priority Partners Member Complaint Policy and Procedures**

Priority Partners has written complaint policies and procedures whereby a member who is dissatisfied with Priority Partners or its network may seek recourse verbally or in writing from the HealthChoice Member Action Line staff. Priority Partners must submit its written internal complaint policy and procedures to the Department for its approval.

Priority Partners internal complaint materials are developed in a culturally sensitive manner, at a suitable reading comprehension level, and in the member’s native tongue if the member is a member of a substantial minority. Priority Partners 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.

Priority Partners includes in its written internal complaint process the procedures for registering and responding to appeals and grievances in a timely fashion. These procedures include resolving emergency medically related grievances within 24 hours, non-emergency medically related grievances within five days and administrative grievances within 30 days. In addition, the written procedures:
• Require documentation of the substance of the complaints and steps taken to resolve;

• Include participation by the provider, if appropriate;

• Allow participation by the ombudsman, if appropriate;

• Ensure the participation of individuals within the MCO who have the authority to require corrective action;

• Include a documented procedure for written notification on the outcome of our determination;

• Include a procedure for immediate notice to the Department of all disputed denials of benefits or services in emergency medical situations;

• Include a procedure for notice to the member through an Adverse Action Letter that meets the approval of the Department of all disputed denials, reductions, suspensions, or terminations of services or benefits;

• Include an appeal process which provides, at its final level, an opportunity for the member to be heard by our Chief Executive Officer, or their designee;

• Include a documented procedure for reporting of all complaints received by us to appropriate parties; and

• Include a protocol for the aggregation and analysis of complaints and grievance data and use of the data for quality improvement;

No punitive action will be taken against the member for making a complaint against Priority Partners or the Department.

**APPEALS – a request for review of an action**

If the member wants to file an appeal with us, they have to file it within 90 days from the date of receipt of the denial letter.

You can also file an appeal for them if the member signs a form giving you permission. Other people can also help the member to file an appeal such as a family member or a lawyer.

When the member files an appeal, or at any time during our review they should be sure to provide us with any new information they have that will help us make our decision.
When reviewing the member’s appeal we will:

- Use doctors with appropriate clinical expertise in treating the member’s condition or disease;
- Not use the same MCO staff to review the appeal who denied the original request for service; and
- Make a decision about administrative appeals within 30 days

If the member’s provider or Priority Partners feels that the member’s appeal should be reviewed quickly due to the seriousness of the member’s condition, the member will receive a decision about their appeal within three business days.

The appeal process may take up to 44 days if the member asks for more time to submit information or if we need to get additional information from other sources. We will send the member a letter if we need additional information.

If the member’s appeal is about a service that was already authorized and they were already receiving, they may be able to continue to receive the service while we review their appeal. The member should contact us at 800-654-9728 if they would like to continue receiving services while their appeal is reviewed. If the member does not win their appeal, they may have to pay for the services that they received while the appeal was being reviewed.

Once we complete our review, we will send the member a letter letting them know our decision. If we decide that they should not receive the denied service, that letter will tell them how to file another appeal through us or ask for a State Fair Hearing.

**GRIEVANCES**

If the member’s complaint is about something other than not receiving a service, this is a grievance. Examples of grievances would include: not being able to find a doctor, trouble getting an appointment, or not being treated fairly by someone who works at Priority Partners or at the doctor’s office.

If the member’s grievance is:

- About an urgent medical problem that they are having, it will be solved within 24 hours
- About a medical problem, but it is not urgent, it will be solved within 5 days
- Not about a medical problem, it will be solved within 30 days

If a member would like a copy of our official complaint procedure or if they need help filing a complaint, they can call 800-654-9728.
Provider Appeals Process

Johns Hopkins HealthCare (JHHC) will reconsider denial decisions upon request by a provider.

The Appeals process is as follows:

- Providers may file an appeal to request reconsideration of a denial.
- Providers will receive written acknowledgement within 5 business days of receipt of an appeal.
- The first level appeal must be filed within 90 business days after notification of the denial.
- The second level appeal must be filed within 20 business days after notification of the first level appeal decision.
- The first and second level appeals will be resolved within 90 business days of receipt of the first level appeal.
- Written notification of the appeal resolution decision will be generated and sent to the appellant within 30 days.
- Payment for claim denials that have been overturned after the appeal will be paid within 30 days.

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

Appeals should be mailed to:

Johns Hopkins HealthCare LLC
Attention: Appeals Department
6704 Curtis Court
Glen Burnie, MD 21060

Reconsideration

If the treating physician would like to discuss their case with a physician reviewer for reconsideration of their original denial, the physician can call the Care Management Department at 410-424-4480 or 800-261-2421.
DHMH QUALITY OVERSIGHT: COMPLAINT AND APPEAL PROCESSES

The HealthChoice and Acute Care Administration operate the central complaint investigation process. The Enrollee Help Line and the Complaint Resolution and Provider Hotline Units are responsible for the tracking of both provider and member complaints and grievances called into the hotlines, or sent to the Department in writing.

Enrollee Help Line

The Enrollee Help Line (EHL) is available Monday through Friday from 7:30 a.m. to 5:30 p.m. The toll free telephone number is: 800-284-4510 or TDD at 800-735-2258 for the hearing impaired.

The EHL is typically a member’s first contact with the Department. Action line staff is trained to answer questions about the HealthChoice Program. EHL staff will:

- Direct recipients to our member services line when needed;
- Attempt to resolve simple issues by contacting us or other parties as needed; and
- Refer medical issues to the Department’s Complaint Resolution Unit for resolution.

The EHL has the capability to address callers in languages other than English either through bilingual staff or through the use of a language line service.

The EHL uses an automated system for logging and tracking member inquiries and grievances. Information is analyzed monthly and quarterly to determine if specific intervention with a particular MCO is required or changes in State policies and procedures are necessary.

Provider Hotline

The Provider Hotline provides HealthChoice providers access to DHMH staff for grievances and inquiries. Provider Hotline staff respond to general inquiries and resolves complaints from providers concerning member access and quality of care as well as educating providers about the HealthChoice Program. The telephone number for the Provider Hotline is 800-766-8692; TDD 800-735-2258. We will not take any punitive action against you for accessing the Provider Hotline.

As with the EHL, provider inquiries and complaints are tracked and analyzed monthly and quarterly to determine if specific intervention with particular MCOs is required or changes in State policies and procedures are necessary.

COMPLAINT RESOLUTION UNIT

The Complaint Resolution Unit is a unit in the Outreach and Care Coordination Division of the HealthChoice and Acute Care Administration.
Roles and Responsibilities

Calls are referred by either the Enrollee Help Line or the Provider Hotline. With a staff of nurses and a physician consultant trained to address complex issues that may require medical knowledge, the Complaint Resolution Unit serves in the following capacities:

- Advocates on the caller’s behalf to obtain resolution of the issue.
- Communicates with our staff, providers, and advocacy groups to resolve the issue and/or secure possible additional community resources for the member’s care when needed.
- Assists members and providers in navigating the MCO system.
- Utilizes the local health department Ombudsman Program to provide localized assistance.
- Facilitates working with us and our providers to coordinate plans of care that meet the member’s needs.
- Coordinates the State appeal process relating to a denied covered benefit or service for the member.

The Complaint Resolution Unit operates Monday through Friday from 7:30 a.m. to 5:30 p.m. and has the capability to address recipients in languages other than English through the use of a language line service.

Ombudsman/Administrative Care Coordination Unit (ACCU) Program

The Department operates an Ombudsman/ACCU Program for the purpose of investigating disputes between members and managed care organizations referred by the Department’s complaint unit. The ombudsman educates members about the services provided by Priority Partners and their rights and responsibilities in receiving services from us. When appropriate, the ombudsman may advocate on the member’s behalf including assisting the member to resolve a dispute in a timely manner, using our internal grievance and appeals procedure.

The Ombudsman program is operated locally in each county of the State, under the direction of the Department. In most jurisdictions, local health departments carry out the local ombudsman function. A local health department that desires to serve as both the county ombudsman and as a MCO subcontractor must first secure the approval of the Secretary of the Department and of the local governing body. In addition, a local health department may not subcontract the ombudsman program.

Local ombudsman programs include staff with suitable experience and training to address complex issues that may require medical knowledge. When a complaint is referred from the
Department's complaint unit, the local ombudsman may take any or all of the following steps as appropriate:

- Attempt to resolve the dispute by educating the MCO or the member;
- Utilize mediation or other dispute resolution techniques;
- Assist the member in negotiating our internal complaint process; and
- Advocate on behalf of the member throughout our internal grievance and appeals process.

All cases referred to the Ombudsman/ACCU, will be resolved within the timeframe specified by the Department’s Complaint Resolution Unit or within 30 days of the date of referral.

The local ombudsman does not have the authority to compel us to provide disputed services or benefits. If the dispute is one that cannot be resolved by the local ombudsman's intervention, the local ombudsman will refer the dispute back to the Department for resolution. A local health department may not serve as ombudsman for cases in which the dispute between the member and us involves the services of the local health department as a MCO subcontractor. The Department conducts a periodic review of the Ombudsman Program activities as part of the quarterly and annual complaint review process.

**Departmental Dispute Resolution**

When a member does not agree with the MCO’s decision to deny, stop, or reduce a service, the member can appeal the decision. The member can contact the EHL at 1-800-284-4510 and tell the representative that they would like to appeal the MCO’s decision. The appeal will be sent to a nurse in the Complaint Resolution Unit. The Complaint Resolution will attempt to resolve the issue with the MCO in 10 business days. If it cannot be resolved in 10 business days, the member will be sent a notice that gives them a choice to request a fair hearing or wait until the Complaint Resolution Unit has finished its review. When the Complaint Resolution Unit is finished, working on the appeal, the member will be notified of their findings.

If the Department disagrees with our determination, it may order us to provide the benefit or service immediately.

If the Department agrees with our determination to deny a benefit or service, it will issue written notice within 10 business days to the member, stating the grounds for its decision and explaining the member’s appeal rights. The member may exercise their right to an appeal by calling 888-767-0013 or by completing the Request for a Fair Hearing form attached to their appeal letter and sending it to:

Susan J. Tucker, Executive Director  
Attn: Dina Smoot  
Office of Health Services  
201 W. Preston Street, Room 127  
Baltimore, MD  21201
Member Appeal

A HealthChoice member may exercise their appeal rights pursuant to State Government Article, 10-201 et seq., Annotated Code of Maryland. A member may appeal a Departmental decision that: (1) agrees with our determination to deny a benefit or service; (2) denies a waiver-eligible individual's request to disenroll; or (3) denies a member eligibility in the REM program.

The member may appeal a decision to the Office of Administrative Hearings. In appeals concerning the medical necessity of a denied benefit or service, a hearing that meets Department established criteria, as determined by the Department, for an expedited hearing, shall be scheduled by the Office of Administrative Hearings, and a decision shall be rendered within three days of the hearing. In cases other than those that are urgent concerning the medical necessity of a denied benefit or service, the hearing shall be scheduled within 30 days of receipt by the Office of Administrative Hearings of the notice of appeal, and a decision shall be rendered within 30 days of the hearing. The parties to an appeal to the Office of Administrative Hearings, under this section, will be the Department and the member, the member’s representative or the estate representative of a deceased member. We may move to intervene as a party aligned with the Department.

We will provide all relevant records to the Department and provide witnesses for the Department, as required.

Following the hearing, the Office of Administrative Hearings issues a final decision. The final decision of the Office of Administrative Hearings is appealable to the Board of Review pursuant to Health-General Article, 2-201 to 2-207, Annotated Code of Maryland. The decision of the Board of Review 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.
Section VII
CORRECTIVE MANAGED CARE
CORRECTIVE MANAGED CARE

Suspected Pharmacy Misuse Process and Procedures

Priority Partners members suspected of misusing opiate prescriptions may be placed in a Corrective Managed Care Program (CMCP).

1. Potential candidates:
   a. Greater than or equal to six opiate prescriptions and greater than or equal to three different providers in a one-month period.
   b. Two or more opiate prescriptions each for at least 360 doses in a three-month period.
   c. Discharged by a provider from his or her panel because of suspected opiate prescription fraud.

2. The primary care provider and/or specialty care provider is contacted by phone to clarify if there could be a documented valid medical reason for the suspicion.

3. The Corrective Managed Care Committee (CMCC) will review the member’s available medical claims history, provider comments, and any other data then decide if the member should be in a CMCP.

4. A Behavioral Health Coordinator contacts the member to discuss the concerns and explains that if the behavior continues the member would be placed in Corrective Managed Care. The coordinator offers assistance for appropriate behavior and or substance abuse treatment. The coordinator explains what corrective managed care is.

5. The Behavioral Health Coordinator sends the member a certified letter. The letter discusses the concerns, expectations for the member’s appropriate behavior, offers assistance to the member, and explains the CMCP if the member’s behavior does not change. This letter is also sent if attempted telephone contacts are unsuccessful.

6. If the member’s behavior continues, the CMCC sends a certified letter to the member stating:
   a. The reason or reasons why the member was found to have abused benefits;
   b. A statement that the member will be enrolled in corrective managed care and the effective date and duration of that enrollment; and
   c. A statement that the member may identify a preference for an assigned primary medical care provider, specialty care provider, or pharmacy.
   Copies of the letter will be sent to the member’s primary care provider and specialists.

7. If the letter is returned as undeliverable, the Behavioral Health Outreach department will attempt to locate the member.

8. A 30-day waiting period is allowed for the member to respond to the notification of being placed in a CMCP.
9. The CMCC selects primary care, and/or specialty care and/or pharmacy providers. One or more restrictions may be used depending on the member’s situation. The proposed primary care and/or specialty care providers are contacted to verify that they are willing to participate in the member’s CMCP.

10. The member will be notified in writing of his providers and pharmacy names, addresses and telephone numbers.

11. Once enrolled in the program, PPMCO will only reimburse for opiate prescriptions written by the specified providers and filled at the specified pharmacy/pharmacy chain. In urgent or emergent situations pharmacies are allowed to dispense 72-hours of opiate medications.

12. The PPMCO Pharmacy department will restrict the member to the specified pharmacy, and prescriptions for opiates will only be filled when written by the specified providers. Restriction to specific providers might not be possible for large group practices.

13. The member will receive support from the Priority Partners’ Substance Abuse department. Substance abuse treatment resources will be identified for the member as necessary.

14. Corrective Managed Care files will be kept in the Behavioral Health department. A secure internal on-line database will be maintained for use by Behavioral Health staff and Medical Director for documenting contacts with members and appropriate.

15. Enrollment Periods:
   a. The initial period is six calendar months.
   b. A member who has completed the period of enrollment and who is subsequently found to have misused MCO benefits for a second time shall be enrolled for an additional 12 calendar months.
   c. A member who has been found on three separate determinations to abuse MCO benefits shall be enrolled for a period of 24 calendar months.
   d. A member found to have abused MCO benefits while enrolled in corrective managed care shall have the enrollment period extended for an additional 18 calendar months.

16. A member placed in corrective managed care may appeal the decision in accordance with COMAR 10.09.72.05.

17. Members suspected of Medicaid fraud will be reported to the Administrative Office for reporting to Medicaid Fraud Control Unit in accordance with COMAR 10.09.65.02Q.
18. A monthly Excel report will be submitted to DHMH by Priority Partners administrative department and will contain the following information:
   a. Recipient’s name
   b. Medical Assistance number
   c. Length of enrollment period in CMC
   d. Date of CMC enrollment letter to recipient
   e. Appeal received? Yes/no
   f. Status of outcome of appeal
   g. Actual effective date of enrollment into CMC
   h. Actual termination date from CMC
Section VIII
ADDITIONAL PRIORITY PARTNERS
INFORMATION
## Important Phone Numbers

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<thead>
<tr>
<th>Priority Partners</th>
<th>Utilization/Care Management</th>
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<tr>
<td>800-654-9728</td>
<td>410-424-4480</td>
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<tr>
<td><strong>Provider First Line</strong></td>
<td>800-261-2421</td>
</tr>
<tr>
<td>888-819-1043</td>
<td>410-424-4603 Fax</td>
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<tr>
<td><strong>Provider Relations</strong></td>
<td>(Referral not needing Medical Review)</td>
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<tr>
<td>410-762-5385</td>
<td><strong>Inpatient</strong></td>
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<tr>
<td>888-895-4998</td>
<td>410-424-4894 Fax</td>
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<td>410-424-4604 fax</td>
<td><strong>Outpatient Medical Review</strong></td>
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<tr>
<td><strong>Priority Partners (Referrals)</strong></td>
<td>410-762-5205 Fax</td>
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<tr>
<td>410-424-4603 fax</td>
<td><strong>DME</strong></td>
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<tr>
<td><strong>Eligibility Verification System</strong></td>
<td>410-762-5250 Fax</td>
</tr>
<tr>
<td>866-710-1447</td>
<td><strong>Dental (DentaQuest)</strong></td>
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<tr>
<td><strong>Mental Health Services (MAPS)</strong></td>
<td>888-696-9596</td>
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<td>800-888-1965</td>
<td><strong>HealthChoice</strong></td>
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<td><strong>Behavioral Health Services</strong></td>
<td>800-977-7388</td>
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<td>410-424-4476</td>
<td><strong>Health Education</strong></td>
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<td>410-424-4821</td>
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<td><strong>Block Vision Services</strong></td>
<td>866-438-8911</td>
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<td>800-428-8789</td>
<td><strong>Outreach</strong></td>
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<td><strong>JHHC Corporate Compliance</strong></td>
<td>410-424-4648</td>
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<td>410-424-4996</td>
<td>888-500-8786</td>
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<tr>
<td>410-424-4996 fax</td>
<td><strong>Referral (Fax)</strong></td>
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<td><a href="mailto:compliance@jhhc.com">compliance@jhhc.com</a></td>
<td>410-424-4603</td>
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Priority Partners Identification Card

Name: PRIORITY PART SAMPLE CARD

ID #: 000008539*01

Case #: 333222111

Doctor: JHCP AT CANTON CROSSING

Doctor Phone: (410)522-8940

Group #: P00100

Bin #610084

PRIORITY PARTNERS BENEFITS

Call Priority Partners at 1-800-654-9728 prior to any inpatient admission or within 24 hours of urgent/emergency inpatient admission.

CUSTOMER SERVICE and BENEFIT INFORMATION

Call Priority Partners at 1-800-654-9728

DENTAL BENEFIT INFORMATION

1-800-608-9611

SUBSTANCE ABUSE CARE

For coordination and pre-authorization of coverage for outpatient and inpatient care, call toll free 1-800-251-2429

SUBMIT CLAIMS TO:

Priority Partners, MCO

 Suite 203, Curtis Court, Glen Burnie, MD 21060

HEALTHCHOICE ENROLLEE ACTION LINE 1-800-284-4510
FORMS
www.ppmco.org

The below listed forms can be located on the Priority Partners website at www.ppmco.org:

- 2009 MD Report Card
- Authorization for Release of Health Information Form - Standing
- Authorization for Release of Health Information Form - Unique One Time
- Behavioral Health Referral Assessment
- Health Educator Referral Form
- Maternity & Newborn Admissions Authorization Form
- Newborn Enrollment Notification Form
- Outreach Services Referral Form
- Pharmacy Pre-Authorization Form
- Primary Care Provider Change Form
- Priority Partners Member Change of Address Form
- Same Day Procedure Pre-Authorization Form
- Special Needs Referral Form
- Suboxone-Subutex Pre-Authorization Form
- Synagis Pre-Authorization Form
## SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

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

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- **Chief Complaint:** Age:

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

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</tr>
<tr>
<td>Mouth: Pharynx without erythema, swelling, or exudate</td>
</tr>
<tr>
<td>Neck: Full ROM. No tenderness</td>
</tr>
<tr>
<td>Lymph Nodes: No lymphadenopathy</td>
</tr>
</tbody>
</table>

| Cardiac: DRR, normal S1 S2, no murmur |
| Lungs: CTA bilaterally, no retractions, wheezes, rales, rhonchi |
| Abdomen: Soft, non-tender, no HSM, no masses |
| Extremities: GRROM |

<table>
<thead>
<tr>
<th>Rx Ordered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labs Ordered:</td>
</tr>
<tr>
<td>Radiology Services Ordered:</td>
</tr>
</tbody>
</table>

For MCO formulary info, find MCO website at:
http://dhmh.state.md.us/mmg/healthchoice/

Provider Signature: DHMH 7-10-2009/ch

**PCP F/U Required:**
- Yes
- No
Automated Voice Response Unit (AVRU)

The Automated Voice Response Unit, or AVRU, is an Automated Referral/Authorization and Claim review system that allows Johns Hopkins HealthCare network providers the convenience of checking referral and claim information for members via the telephone.

Providers will have two options in terms of receiving referral/authorization or claim information:

- **Interactive mode (IM):** Callers listen to detailed information on each referral/authorization and determine if they wish to receive fax-back information.

- **Fax mode (FAX):** Callers enter provider and member IDs. The system verifies the information and tells the caller how many referrals/authorizations match the entered data. The system adds the information to a log file which can be faxed (if desired) upon the completion of the call.

Important: In order to access the system, you will need to enter your provider identification number. It can be found on your “Provider Welcome Letter”, or this directory. You must also have your member’s identification number available in order to access information in the system.

### Accessing the AVRU

#### Referral/Authorization Menu

**Interactive Mode**

Dial 410-424-4490 or 888-819-1043

After selecting **Option 2**, you will hear, “You have reached the Johns Hopkins HealthCare Main Menu. To review existing referrals, Press 3.

**Step 1** - If you would like to interactively retrieve referral information, **Press 1**. To receive an automatic fax-back of the last 10 matching referrals, **Press 2**.

**Step 2** - To enter the PCP number, **Press 1** followed by the pound (#) sign. To enter the Specialist ID number, **Press 2** followed by the pound (#) sign.

**Step 3** - Select **Option 1** to enter the member’s ID number.

**Select Option 2** to enter the member’s Medicaid number.

**Step 4** - Enter the member’s ID number including the asterisk (*) or their Medicaid number.

**Step 5** - To search for referrals in the last year, **Press 1**. To enter a date range, **Press 2**. Enter beginning and end date. (For date range, enter 2 digits for month, day and year 00/00/00).

**Step 6** - To have referral information faxed, **Press 5**. Enter your 10-digit fax number.
Accessing the AVRU
Claims Menu
Interactive Mode
Dial 410-424-4490 or 888-819-1043

After selecting **Option 2**, you will hear, “You have reached the Johns Hopkins HealthCare Main Menu.” To connect to the Status of Claims System, **Press 2**.

**Step 1** - To use this system in interactive mode and to review individual claims, **Press 1**. To use fax-back mode on multiple claims and to receive a summary fax, **Press 2**.

**Step 2** - Enter your JHHC Billing ID number or the Servicing Provider ID number followed by the pound (#) sign.

**Step 3** - Select **Option 1** to enter the member’s ID number
Select **Option 2** to enter the member’s Medicaid number.

**Step 4** - Enter the member’s identification number including the asterisk (*) or Medicaid number.

**Step 5** - Enter the beginning date for the claim (for date range, enter 2 digits for month, day and year 00/00/00).

**Step 6** - To receive a fax back copy of the information entered, Press 1 and enter your 10-digit fax number. If you don’t want to receive a copy, **Press 2**.
CLINICAL PRACTICE GUIDELINES

This section contains guidelines developed to assist practitioners and members to make decisions about appropriate health care for special clinical circumstances. The use of these guidelines allows for measurement of their impact on outcomes and may reduce inter-practitioner variation in diagnosis and treatment. Every attempt has been made to incorporate the latest scientific basis and expert opinion into these guidelines. Of course it will be necessary to periodically revise and update this material.

CHILDREN WITH SPECIAL NEEDS
approved by Michael Crocetti MD, JHBMC Pediatrics


**Section 3-1. NICU**

(a) Approved by Susan Aucott MD, JHH Neonatology


**Section 3-2. COPD**

approved by Robert Wise MD, JHBMC Pulmonology


**Section 3-3. Asthma**

(a) approved by Greg Diette MD, JHH Pulmonology


**Section 3-4. Telemedicine**

approved by Sheldon Gottlieb MD, JHBMC Cardiology


**Lipids:** Update on Cholesterol Guidelines: More intensive treatment options for higher risk patients. NHLBI, ACC, AHA endorsed report, 2004 update to the National Cholesterol Education program’s (NCEP) clinical practice guidelines on cholesterol management. The update was published July 13, 2004 issue of Circulation: Journal of the American Heart Assn.

**ESRD**

approved by Paul Scheel MD, JHH Nephrology


**Partners with Mom**

approved by Wanda Nicholson MD, JHH OB/GYN


Sibai BM. Diagnosis and management of Gestational Hypertension and Preeclampsia. The American College of Obstetricians and Gynecologist. 2003; 102: 181-192


Public Health Service Task Force Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States - December 17, 2004
http://aidsinfo.nih.gov/guidelines/default_db2.asp?id=66


http://aidsinfo.nih.gov/guidelines/default_db2.asp?id=66

Omega Life
approved by Sydney Dy MD, JHH Medicine/Oncology

www.nationalconsensusproject.org

www.nccn.org

Physical Rehabilitation
approved by Kathleen Eaton MD, JHH Physical Medicine/Rehabilitation

BRAIN INJURY


MULTIPLE SCLEROSIS

MS Council for Clinical Practice Guidelines
  • Fatigue and Multiple Sclerosis: Evidence Based Management Strategies for Fatigue in Multiple Sclerosis (October 1998)
  • Urinary Dysfunction and Multiple Sclerosis: Evidence Based Strategies for Dysfunction in Multiple Sclerosis (March 1999)
  • Immunizations and Multiple Sclerosis: Evidence Based Strategies for Immunizations in Multiple Sclerosis Patients (November 2001)
  • Disease Modifying Therapies in Multiple Sclerosis: Evidence Based management Strategies for Disease Modifying Therapies in Multiple Sclerosis (October 2001)

http://www.pva.org/prof/ms/mspubs.htm

SPINAL CORD INJURY

Consortium for Spinal Cord Medicine Clinical Practice Guidelines
  • Depression Following Spinal Cord Injury: A Clinical Practice Guideline for Primary Care Physicians (January 2002)
  • Neurogenic Bowel Management in Adults with Spinal Cord Injury: Clinical Practice Guidelines (March 1998)
  • Outcomes Following Traumatic Spinal Cord Injury Clinical Practice Guidelines for Healthcare Professionals (July 1999)
  • Prevention of Thromboembolism in Spinal Cord Injury, 2nd Edition (September 1999)

http://www.pva.org/res/cpg/tools.htm

STROKE

Management of Stroke Rehabilitation Care (February 2003)
http://www.oqp.med.va.gov/cpg/STR/STR_base.htm


**PAIN MANAGEMENT**


American Pain Society. Pain Control in the Primary Care Setting. 2005  
http://www.ampainsoc.org/

**HIV/AIDS**

approved by John Bartlett MD, JHH Medicine/Infectious Diseases

Johns Hopkins AIDS service guidelines:  
http://hopkins-aids.edu/guidelines/guidelines.html

US Dept of Health and Human Services Guidelines on Antiretroviral treatment, Maternal-Child transmission, Post-exposure prophylaxis, Management of HIV Complications, and testing  
http://aidsinfo.nih.gov/guidelines/  
Additional Guidelines

- *Morbidity and Mortality Weekly Report (MMWR)* by the Centers for Disease Control and Prevention (http://www.cdc.gov/mmwr)

- United States Department of Health and Human Services (DHHS)  
  (http://www.dhhs.gov)

  (http://www.journals.uchicago.edu/CID/home.html)

  Infectious Diseases Society of America (IDSA) (http://www.idsociety.org)