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 about 750,000 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 enrollees 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 six 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 Riverside Health may provide. This section also identifies benefit limitations and services that are not the responsibility of Riverside Health.

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 Riverside Health’s network. This section details the services.

Section V - Rare and Expensive Case Management (REM). Enrollees with certain diagnoses may disenroll from Riverside Health 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 Riverside Health may engage in.
Riverside Health Provider Manual

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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, with the exception of the following categories:

- Individuals who receive Medicare;
- Individuals age 65 or over;
- Individuals who are eligible for Medicaid under spend down;
- Medicaid enrollees 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);
- Enrollees enrolled in the Model Waiver;
- Enrollees 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 enrollees 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 Riverside Health, or with the management group(s) that contract on your behalf with Riverside Health. 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 enrollees are assigned to Riverside Health before rendering services.

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

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

Self-Referral and Emergency Services
Riverside Health 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 an enrollee 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 enrollees 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;
- An initial assessment for substance abuse; and
- 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.
- Services performed at a birthing center, including an out-of-state center.

Self-Referred Services for Children with Special Healthcare Needs
Children with special healthcare needs may self-refer to providers outside of the Riverside Health network under certain conditions. Self-referral for children with special needs is intended to ensure continuity of care and appropriate plans of care. Self-referral for children with special healthcare needs will depend on whether or not the condition that is the basis for the child’s
special health care needs is diagnosed before or after the child’s initial enrollment in Riverside Health. 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 Enrollee:** 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 Riverside Health, and we approve the services as medically necessary.

- **Established Enrollee:** A child who is already enrolled in Riverside Health 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 enrollee’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, enrollees have an appeal right, regardless of whether they are a new or established enrollee. 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 enrollees 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

- Riverside Health’s reduction of your reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to Riverside Health by the Department, and Riverside Health 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 enrollees until an initial evaluation is completed and we develop a new plan of care.

The following steps are to be taken to ensure that enrollees continue to receive necessary health services at the time of enrollment into Riverside Health:

- 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 Riverside Health 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 enrollee 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 1-800-284-4510. 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. The appeal must involve the termination, suspension or reduction of a previously authorized service, have been ordered by a Riverside Health network provider and not have an expired authorization period. 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 1-800-730-8543 or the Provider Hotline (800-766-8692) for assistance.

**Transportation**
You may contact the Local Health Department (LHD) to assist enrollees in accessing non-emergency transportation services. Riverside Health will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD. Should transportation be unavailable through the LHD, Riverside Health will also provide non-emergent transportation.

We will provide non-emergency transportation necessary for our enrollees 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.
Reporting Communicable Disease
You must ensure that all cases of reportable communicable disease that are detected or suspected in an enrollee by either a clinician or a laboratory are reported to the 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 an enrollee has a reportable communicable disease or condition that endangers public health, or that an outbreak of a reportable communicable disease or public health-endangering condition has occurred, must submit a report to the health officer for the jurisdiction where the provider cares for the enrollee.

- The provider report must identify the disease or suspected disease and demographics on the enrollee including the name, age, race, sex and address of residence, hospitalization, date of death, etc. on a form provided by the Department (DHMH) 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.
In order to be in compliance with the Maryland HIV/AIDS reporting Act of 2007, Laboratory providers must report HIV positive members and all CD4 test results to the Health Department by using the member’s name. The State of Maryland HIV/CD4 Laboratory Report Form DHMH 4492 must be used. The reporting law and the revised reporting forms may be found at the following website:

Http:// mmcp.dhmh.maryland.gov/ehr/SitePages/Laboratory-reporting.aspx

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:

Amebiasis
Anaplasmosis
Animal bites
Anthrax
Arboviral infections
Babesiosis
Botulism
Brucellosis
Campylobacter infection
Chancroid
Chlamydia infection
Cholera
Coccidioidomycosis
Creutzfeld-Jakob disease
Cryptosporidiosis
Cyclosporiasis
Dengue fever
Diphtheria
Ehrlichiosis
Encephalitis
Epsilon toxin of Clostridium perfringens
Escherichia coli O157:H7 infection
Giardiasis
Glanders
Gonococcal infection
Haemophilus influenzae, invasive disease
Hantavirus infection
Microsporidiosis
Mumps (infectious parotitis)
Mycobacteriosis, other than tuberculosis and leprosy
Novel influenza A virus infection
Pertussis
Pertussis vaccine adverse reactions
Pesticide related illness
Plague
Pneumonia in a healthcare worker resulting in hospitalization
Poliomyelitis
Psittacosis
Q Fever
Rabies
Ricin toxin
Rocky Mountain spotted fever
Rubella (German measles) and congenital rubella syndrome
Salmonellosis (non-typhoid fever types)
Septicemia in newborns
Severe acute respiratory syndrome (SARS)
Shiga-like toxin producing enteric bacterial infections
Shigellosis
Smallpox and other Orthopoxvirus infections
Harmful algal bloom related illness
Hemolytic uremic syndrome, post-diarrheal
Hepatitis, Viral (A,B,C, Delta, non-ABC, E, F, G, undetermined)
Influenza-associated pediatric mortality
Isosporiasis
Kawasaki syndrome
Legionellosis
LaCrosse virus infection
Leprosy
Leptospirosis
Listeriosis
Lyme disease
Malaria
Marlaria
Measles (rubeola)
Melioidois
Meningitis, infectious
Meningococcal invasive disease
Staphylococcal enterotoxin B
Streptococcal invasive disease, Group A
Streptococcal invasive disease, Group B
Streptococcal invasive disease, Group A
Syphilis
Tetanus
Trichinosis
Tuberculosis and suspected tuberculosis
Tularemia
Typhoid fever (case or carrier, or both, of Salmonella typhi)
Vancomycin-intermed Staph Aureus (VISA)
Vancomycin-resistant Staph (VRSA)
Varicella (chickenpox), fatal cases only
Vibriosis, non-cholera types
Viral hemorrhagic fever (all types)
Yellow fever
Yersiniosis

**Appointment Scheduling and Outreach Requirements**

In order to ensure that HealthChoice enrollees 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 enrollees into care:

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

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

Prior to any appointment for a HealthChoice enrollee you must call EVS at 1-866-710-1447 to verify enrollee eligibility and MCO enrollment. This procedure will assist in ensuring payment for services.

If a member does not keep his or her appointment and fails to notify your office, please contact us at 1-800-730-8543 or by fax at (410) 779-9336. We will assist you with bringing the member into care by outreaching to the member. It is especially important that you refer those members who are known to be at risk.
Initial Health Appointment for HealthChoice Enrollees
HealthChoice enrollees 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 enrollee 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 enrollees 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 enrollee for conditions requiring expedited intervention by providers. HealthChoice enrollees who screen positive must be seen for their initial health visit within 15 days of Riverside Health’s 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 enrollee, or laboratory findings indicate possible substance abuse, you are to perform a substance abuse screening using approved Substance Abuse and Mental Health Services Administration (SAMHSA) screening instrument and appropriate for the age of the member.

Services for Children
For children younger than 21 years old, we shall assign the enrollee to a PCP who is certified by the EPSDT Program, unless the enrollee or enrollee’s parent, guardian, or care taker, 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 childcare 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 enrollees 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 enrollee information about hematocrits and nutrition status to assist in determining an enrollee’s eligibility for WIC.

- Participate in the Vaccines For Children (VFC) Program. Many of the routine childhood immunizations are furnished under the VFC Program. The VFC Program provides free vaccines for health care providers who participate in the VFC Program. 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.

Enrollees 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 enrollee 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, care givers or guardians who are difficult to reach, or repeatedly fail to comply with a regimen of treatment for the child, you should follow the procedures below to bring the child into care:

- Document outreach efforts in the medical record. These efforts should include attempts to notify the enrollee by mail, by telephone, and through face-to-face contact.

- Notify our Health Services at 1-800-730-8543 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 http://mmcp.dhmh.maryland.gov/SitePages/Local%20Health%20Services%20Request%20Form.aspx)

- After referring to the ACCU, work collaboratively with the ACCU and Riverside Health 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 enrollee.

- 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 enrollee or the PCP, a case manager who is either a nurse or a social worker will be assigned to the enrollee. The case manager will work with the enrollee 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 enrollee 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 enrollees 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 enrollees 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 an enrollee continues to miss appointments, Riverside Health must be informed. We will attempt to contact the enrollee by mail, telephone and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the local health department in the jurisdiction where the enrollee 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 enrollee for the purpose of encouraging them to seek care. After referral to the ACCU, Riverside Health and our providers will work collaboratively with the ACCU to bring the enrollee into care.

**Services for Pregnant and Post-Partum Women**
Riverside Health 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; and
- Referral to the ACCU.

The PCP, OB/GYN and Riverside Health are responsible for making appropriate referrals of pregnant enrollees 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 enrollee 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 on page 19) for each pregnant enrollee and submit it to the Local Health Department in the jurisdiction in which the enrollee lives within 10 days of the initial visit.
- For pregnant enrollees under the age of 21, refer them to their PCP to have their EPSDT screening services provided.
- Reschedule appointments within 10 days for enrollees who miss prenatal appointments.
- Refer to the WIC Program.
- Refer pregnant and postpartum enrollees 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 enrollee to notify the MCO of her pregnancy and her expected date of delivery after her initial prenatal visit.
- Instruct the pregnant enrollee to contact the MCO for assistance in choosing a PCP for the newborn prior to her eighth month of pregnancy.
- Document the pregnant enrollee’s choice of pediatric provider in the medical record.
- Advise pregnant enrollee 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**

*REFER TO INSTRUCTIONS ON BACK BEFORE STARTING*

| Provider Name: ________________________________ | Provider Phone Number: ______ - ______ - ______ |
| Client Last Name: ______________________________ | First Name: _____________________________ |
| House Number: ______ Street Name: __________________ Apt: ______ - ______ - ______ |
| County (if patient lives in Baltimore City, leave blank): __________________ State: ______ Zip Code: ______ |
| Home Phone#: ______ - ______ - ______ | Cell Phone#: ______ - ______ - ______ | Emergency Phone#: ______ - ______ - ______ |
| SSN: ______ / ______ / ______ | DOB: ______ / ______ / ______ | Name & Relationship of Emergency Contact: ______________________ |

**DEMOGRAPHIC INFORMATION**

| Race: | Language Barrier? | Payment Status (Mark all that apply): |
| African American or Black | _____ Yes _____ No | __Private Insurance, Specify: ____________ |
| Alaskan Native | American Native | Specify Primary Language | MA/Health Choice |
| Asian | More than 1 Race | Hispanic? | _____ Yes _____ No | MA # ______________________________ |
| Native Hawaiian or other Pacific Islander | Unknown | White | Marital Status: | Married | Unmarried | Name of MCO (if applicable): ______________________ |

**EDUCATIONAL LEVEL:**

Highest grade completed: __________
Currently in school? ____ Yes ____ No
GED? ____ Yes ____ No

Date of initial prenatal visit: ______ / ______ / ______

**ASSESSMENT INFORMATION**

| OB History: Complete all that apply | Check all that apply |
| _____ # Full-term live births | _History of pre-term labor |
| _____ # Pre-term live births | _History of fetal death (> 20 wks) |
| _____ # Prior LBW births | _History of infant death w/in 1 yr of age |
| _____ # Spontaneous abortions | _History of multiple gestation |
| _____ # Therapeutic abortions | _History of infertility treatment |
| _____ # Ectopic Pregnancies | _First Pregnancy |
| _____ # Children now living | |

| Psychosocial Risks: Check all that apply. | Medical Risks: Check all that apply. |
| _____ Current pregnancy unintended | Current Medical Conditions of this Pregnancy: |
| _____ Less than 1 year since last delivery | _ Age ≤ 15 |
| _____ Late registration (more than 20 weeks gestation) | _ Age ≥ 45 |
| _____ Disability (mental/physical/developmental), Specify ____________ | _ BMI < 18.5 or BMI > 30 |
| _____ History of abuse/violence within past 6 months | _ Hypertension (> 140/90) |
| _____ Tobacco use, Amount ____________ | _ Anemia (Hgb < 10 or Hct < 30) |
| _____ Alcohol use, Amount ____________ | _ Asthma |
| _____ Illegal substances within past 6 months | _ Sickle cell disease |
| _____ Resides in home built prior to 1978, ____ Rent ____ Own | _ Diabetes: Insulin dependent | _____ Yes ____ No |
| _____ Homelessness | _ Vaginal bleeding (after 12 weeks) |
| _____ Lack of social/emotional support | _ Genetic risk: specify ____________ |
| _____ Exposure to long-term stress | _ Sexually transmitted disease, Specify ____________ |
| _____ Lack of transportation | _ Last dental visit over 1 year ago |
| _____ Other psychosocial risk (specify in comments box) | _ Prescription drugs, Specify ____________ |
| _____ None of the above | _ History of depression/mental illness, Specify ____________ |

**COMMENTS ON PSYCHOSOCIAL RISKS:**

**COMMENTS ON MEDICAL RISKS:**

| Depression assessment completed? | _____ Yes ____ No |
| _____ Other medical risk (specify in comments box) | _ None of the above |

Form Completed By: _________________________
Date Form Completed: ______ / ______ / ______
DHMH 4850 Revised 05/28/09
**Purpose of Form:** Identifies pregnant woman who may benefit from local health department Administrative Care Coordination (ACCU) services and serves as the referral mechanism. ACCU services complement medical care and may be provided by public health nurses and social workers through the local health departments. Services may include resource linkage, psychosocial/environmental assessment, reinforcement of the medical plan of care, and other related services.

**Form Instructions:** On the initial visit the provider/staff will complete the demographic and assessment sections for ALL pregnant women enrolled in Medicaid at registration and those applying for Medicaid.

- Print clearly; use black pen for all sections.
- Press firmly to imprint.
- White-out previous entries on original completely to make corrections.
- If client does not have a social security number, indicate zeroes.
- Indicate the person completing the form.
- Review for completeness and accuracy.

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

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

<table>
<thead>
<tr>
<th>RISK</th>
<th>DEFINITION OF RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol use</td>
<td>Is a “risk drinker” as determined by a screening tool such as MAST, CAGE, TACE, TACE or 4Ps</td>
</tr>
<tr>
<td>Current history of abuse/violence</td>
<td>Includes physical, psychological abuse or violence within the client’s environment within the past six months.</td>
</tr>
<tr>
<td>Exposure to long-term stress</td>
<td>For example: partner-related, financial, safety, emotional</td>
</tr>
<tr>
<td>Genetic risk</td>
<td>At risk for a genetic or hereditary condition</td>
</tr>
<tr>
<td>Illegal Substances</td>
<td>Used illegal substances within the past 6 months (e.g. cocaine, heroin, marijuana, PCP) or is taking methadone/buprenorphine</td>
</tr>
<tr>
<td>Lack of social/emotional support</td>
<td>Absence of support from family/friends, isolated</td>
</tr>
<tr>
<td>Language barrier</td>
<td>In need of interpreter, e.g. Non-English speaking, auditory processing disability, deaf</td>
</tr>
<tr>
<td>Oral hygiene</td>
<td>Last dental visit over 1 year ago</td>
</tr>
<tr>
<td>Preterm live birth</td>
<td>History of preterm labor (prior to the 37th gestational week)</td>
</tr>
<tr>
<td>Prior LBW birth</td>
<td>Low birth weight birth (under 2,500 grams)</td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td>Documented by medical records</td>
</tr>
<tr>
<td>Tobacco use</td>
<td>Used any type of tobacco products within the past 6 months</td>
</tr>
</tbody>
</table>

**Client’s Local Health Department Addresses**

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegany County ACCU</td>
<td>301-759-5094 Fax: 301-777-2401</td>
</tr>
<tr>
<td>Anne Arundel County ACCU</td>
<td>410-222-7541 Fax: 410-222-4150</td>
</tr>
<tr>
<td>Baltimore HealthCare Access</td>
<td>410-640-0526 Fax: 1-888-657-8712</td>
</tr>
<tr>
<td>Baltimore County ACCU</td>
<td>410-887-8741 Fax: 410-828-8346</td>
</tr>
<tr>
<td>Calvert County ACCU</td>
<td>410-535-5400 Fax: 410-535-1955</td>
</tr>
<tr>
<td>Caroline County ACCU</td>
<td>410-479-8023 Fax: 410-479-4871</td>
</tr>
<tr>
<td>Carroll County ACCU</td>
<td>410-876-4940 Fax: 410-876-4959</td>
</tr>
<tr>
<td>Cecil County ACCU</td>
<td>410-996-5145 Fax: 410-996-5121</td>
</tr>
<tr>
<td>Charles County ACCU</td>
<td>301-609-6803 Fax: 301-934-7048</td>
</tr>
<tr>
<td>Dorchester County ACCU</td>
<td>410-228-3294 Fax: 410-228-8976</td>
</tr>
<tr>
<td>Frederick County ACCU</td>
<td>301-600-3348 Fax: 301-600-3302</td>
</tr>
<tr>
<td>Garrett County ACCU</td>
<td>301-334-7777 Fax: 301-334-7771</td>
</tr>
<tr>
<td>Harford County ACCU</td>
<td>410-273-5626 Fax: 410-272-5467</td>
</tr>
<tr>
<td>Howard County ACCU</td>
<td>410-313-7323 Fax: 410-313-5838</td>
</tr>
<tr>
<td>Kent County ACCU</td>
<td>410-778-7023 Fax: 410-778-7019</td>
</tr>
<tr>
<td>Montgomery County ACCU</td>
<td>240-777-1616 Fax: 240-777-4645</td>
</tr>
<tr>
<td>Prince George’s County ACCU</td>
<td>301-883-7231 Fax: 301-883-7572</td>
</tr>
<tr>
<td>Queen Anne’s County ACCU</td>
<td>443-262-4424 Fax: 443-262-9357</td>
</tr>
<tr>
<td>St Mary’s County ACCU</td>
<td>301-475-4951 Fax: 301-475-4110</td>
</tr>
<tr>
<td>Somerset County ACCU</td>
<td>443-523-1723 Fax: 410-651-2572</td>
</tr>
<tr>
<td>Talbot County ACCU</td>
<td>410-819-5600 Fax: 410-819-5691</td>
</tr>
<tr>
<td>Washington County ACCU</td>
<td>240-313-3229 Fax: 240-313-3222</td>
</tr>
<tr>
<td>Wicomico County ACCU</td>
<td>410-543-6942 Fax: 410-543-6568</td>
</tr>
<tr>
<td>Worcester County ACCU</td>
<td>410-629-0164 Fax: 410-629-0185</td>
</tr>
</tbody>
</table>
**Dental Care for Pregnant Enrollees**
Dental services for pregnant women are provided by the Maryland Healthy Smiles Dental Program, administered by DentaQuest. Contact them at 1-888-696-9596 if you have questions about dental benefits.

**Childbirth Related Provisions**
Special rules for length of hospital stay following childbirth:

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

Postnatal home visits 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 an enrollee 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 3-5 days after discharge if there has been a home visit.
**Children with Special Health Care Needs**

Riverside Health 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 detailed on Page 3 of Section I.
- Log any complaints made to the State or to Riverside Health 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 enrollees 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 Riverside Health 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 enrollee’s request. The DES includes a physical, mental and social evaluation. The enrollee 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 enrollees 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 enrollee to receive needed health care services.
Case management services are provided for any enrollee who is diagnosed with HIV. These services are to be provided, with the enrollee’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. Health Services will link HIV-infected enrollees 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 enrollee’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 enrollee and the enrollee’s family by which the case manager and the PCP track services received, clinical outcomes, and the need for additional follow-up.

The enrollee’s case manager will serve as the enrollee’s advocate to resolve differences between the enrollee and providers of care pertaining to the course or content of therapeutic interventions.

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

**Individuals with Physical or Developmental Disabilities**

Before placement of an individual with a physical disability into an intermediate or long-term care facility, Riverside Health 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 communications requirements of individuals with physical disabilities. We are responsible for accommodating hearing impaired enrollees 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 enrollees have access to these services.

Riverside Health contracts with Language Service Associates to provide interpreter services for American Sign Language during office visits. Interpreter service can be arranged by contacting Riverside Health’s Member Services Department at 1-800-730-8543. Interpreter service is at no charge to you or to the member. Telephone assistance is provided by Telecommunication Relay Services. You can access them by calling 711 then provide the member’s telephone number.
**Individuals in Need of Substance Abuse Treatment**

As part of an enrollee’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 enrollee 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 enrollee is in need of substance abuse treatment, a placement appraisal to determine the appropriate level and intensity of care for the enrollee 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 enrollee is referred to, or the enrollee may self-refer to an appropriate substance abuse treatment modality. Substance abuse treatment services covered for all enrollees include:

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

We will not deny substance abuse treatment solely because the enrollee 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 Enrollees with Impaired Cognitive Ability / Psychosocial Problems**
Support and outreach services are available for adult enrollees 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.

**Access and Availability**
Participating providers must:
- Provide coverage 24 hours a day, 7 days a week.
- Ensure another on-call participating provider is available when the provider is unavailable.
- Not substitute hospital emergency rooms or urgent care centers for covering providers.
- Respond to after-hours emergency phone calls within 30 minutes and urgent phone calls within one hour.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Standard Access Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial appointment</td>
<td>Within 90 Days</td>
</tr>
<tr>
<td>New enrollee (high risk)</td>
<td>Within 15 Days of receipt of HRA(Health Risk Assessment)</td>
</tr>
<tr>
<td>Family Planning Services and Initial assessments of pregnant and post-partum woman</td>
<td>Within 10 Days</td>
</tr>
<tr>
<td>Well Child</td>
<td>Within 30 Days</td>
</tr>
<tr>
<td>Initial newborn visit</td>
<td>Within 3-5 Days of Discharge</td>
</tr>
<tr>
<td>Routine/Symptomatic</td>
<td>Within 7 Days</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Within 30 Days</td>
</tr>
<tr>
<td>Dental, Optometry, Lab and X-ray appointments</td>
<td>Within 30 Days</td>
</tr>
<tr>
<td>Dental, Optometry, Lab and X-ray appointments (Urgent)</td>
<td>Within 48 Hours</td>
</tr>
<tr>
<td>Urgent visit</td>
<td>Within Same Day</td>
</tr>
<tr>
<td>Emergency</td>
<td>Immediately</td>
</tr>
</tbody>
</table>

All family members needing appointments will be given approximately concurrent or consecutive appointments.

Members shall wait no longer than 1 hour in the waiting room to be seen for scheduled appointments.
Riverside Health Support Services (Outreach)

A Riverside Health Member Services representative places a welcome call to all new members and conducts an initial health risk assessment. During the welcome call, the representative encourages the member to schedule their initial appointment with their PCP and helps them make the appointment if needed. Riverside Health sends reminders for periodic preventive health appointments. On a monthly basis, Riverside Health will provide PCPs with a list of members due for preventive visits. Case managers also provide outreach to Special Needs members to ensure that the clinical and psychosocial needs of the member are met. Refer to the Special Needs Population sections in this manual for details.

Providers should contact Riverside Health for assistance with reaching non-compliant members and those members that are difficult to reach. Riverside Health’s outreach resources work collaboratively with the LHD and the provider to bring members into care.

Requests for outreach services may be submitted telephonically or by faxing a request:

**Phone 800-730-8543  Fax (410) 779-9336**

A case manager coordinates services among the member, PCP, specialists, and other healthcare vendors. Services are arranged in a manner that is consistent with covered benefits and services, and regularly monitored to ensure timely delivery.

Riverside Health Referral Authorization Process

**Referral Guidelines**

In order to reduce the administrative burden on providers, Riverside Health does not require notification or completion of referral forms. PCPs may simply refer members to specialists, provided that such referrals are in-network specialists. Any referrals to out-of-network providers will require prior authorization from Riverside Health. When referring a member for specialty care, the PCP must document the referral in the member’s medical record.

**After Hours and Emergency Care**

Members are not required to contact their PCP in emergent/urgent situations. The emergency room staff will triage the member to determine whether or not an emergency exists. However, the PCP must provide telephone coverage 24 hours per day/7 days a week.
Authorization Guidelines
Riverside Health requires prior authorization for all inpatient admissions and certain outpatient services. To request prior authorization, the admitting or referring physician, or the facility or provider rendering the service can submit the request in one of the following ways:

- via fax to (410) 779-9336
- via telephone at 800-730-8543.
- Soon you will also be able to submit via our website at www.myriversidehealth.com

Upon receipt of a prior authorization request, Riverside Health will verify member eligibility and benefits. We will make case-by-case determinations based on the individual’s health care needs and medical history, in conjunction with nationally-recognized standards of medical care. If medical necessity criteria are not met on the initial review, the referring provider may discuss the case with a Riverside Health physician who is in the same or similar specialty prior to the determination. If the request is denied, the appropriate denial letter (including the member’s Fair Hearing appeal rights) will be mailed to the requesting provider, member’s PCP, and the member.

To ensure timeliness of prior authorization requests, the requesting provider should include the following information:

- Member name and ID number
- Name, telephone and fax of the facility or provider who will be rendering the service
- Proposed date(s) of service
- Diagnosis with ICD9 code
- Name of procedure(s) with CPT-4 code
- Medical information to support the request
  - Signs and symptoms
  - Past and current treatment plans, including response to treatment plans
  - Medications, along with frequency and dosage

Please visit www.myriversidehealth.com, or call 1-800-730-8543 for the most current version of prior authorization guidelines.

Inpatient Admission Review

Riverside Health reviews inpatient admissions within one business day of notification. We determine the member’s status through:

- Onsite review, when indicated
- Communication with the hospital’s utilization review department

We then document the appropriateness of stay and refer specific diagnoses to our Health Services department for care coordination or case management.
**Inpatient Concurrent Review**

To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record:

- At the hospital when indicated
- Via telephone or fax

We conduct select continued stay reviews daily and review discharge plans. Our Utilization management (UM) clinician will also try to meet with the member and/or family to:

- Discuss any discharge planning needs
- Verify they know the PCP’s name and address

We authorize the covered length of stay one day at a time. Our medical director can make exceptions for severe illness and course of treatment or when it is pre-determined by state law. Examples include:

- ICU, CCU
- C-section or vaginal deliveries

We will communicate approved days and bed level coverage to the hospital for any continued stay.

**Discharge Planning**

Riverside Health’s utilization management (UM) clinician coordinates our members’ discharge planning needs with:

- Hospital utilization review/discharge planning staff
- The attending physician
- The Riverside Health Services department

The attending physician, in concert with our UM clinician or Health Services Representative, coordinates the member’s follow up care with the member’s PCP.

For ongoing care, we work with the provider to plan discharge to an appropriate setting such as:

- Hospice
- Convalescent care
- Home health care program
- Skilled nursing facility
Authorization Grid

Please visit www.myriversidehealth.com, or call 1-800-730-8543 for the most current version of prior authorization guidelines.

<table>
<thead>
<tr>
<th>Service</th>
<th>Prior Authorization Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>No prior authorization required.</td>
</tr>
<tr>
<td>Audiology</td>
<td>Not covered for adults 21 years of age or older</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Prior authorization is required.</td>
</tr>
<tr>
<td>Cardiology</td>
<td>No prior authorization is required.</td>
</tr>
<tr>
<td>Cardiac Catheterization</td>
<td>No prior authorization is required for outpatient procedures</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>No prior authorization is required.</td>
</tr>
<tr>
<td>Circumcision</td>
<td>No prior authorization is required.</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>Prior authorization is required.</td>
</tr>
<tr>
<td>Dermatology</td>
<td>No prior authorization is required for E&amp;M or Testing.</td>
</tr>
<tr>
<td></td>
<td>Some procedures may require prior authorization.</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>Prior authorization is required for MRIs, MRAs, PET, EEG, Nuclear Testing, MEG, CT Angiogram, Deca Scan</td>
</tr>
<tr>
<td>Diabetic supplies</td>
<td>No prior authorization required.</td>
</tr>
<tr>
<td>Diabetic shoes</td>
<td>No prior authorization required.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>No prior authorization is required for DME below $500</td>
</tr>
<tr>
<td></td>
<td>Prior authorization is required for all DME that exceeds $500</td>
</tr>
<tr>
<td></td>
<td>DME rentals are capped at the purchase price.</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visit</td>
<td>No prior authorization is required for outpatient services. PCPs are required to use the EPSDT schedule and to document the visits. Note: vaccine serum is received under the Vaccines for Children (VFC) program</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>No prior authorization is required. Note: Riverside Health must be notified within 24 hours or the next business day if a member is admitted to the hospital through the emergency room</td>
</tr>
<tr>
<td>ENT Services (Otolaryngology)</td>
<td>No prior authorization is required for out-patient services</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>No prior authorization is required.</td>
</tr>
<tr>
<td>Family Planning</td>
<td>No prior authorization required. Members may self-refer for family planning services</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>No prior authorization is required for outpatient services</td>
</tr>
<tr>
<td>General Surgery</td>
<td>No prior authorization is required for outpatient or ambulatory surgery center</td>
</tr>
<tr>
<td>Gynecology</td>
<td>No prior authorization is required for outpatient services</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Covered by the State for &lt;21</td>
</tr>
<tr>
<td>Hearing Screening</td>
<td>Not A Covered Benefit for &gt;21 years of age</td>
</tr>
<tr>
<td>Service</td>
<td>Prior Authorization Guidelines</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hematology</td>
<td>No prior authorization is required</td>
</tr>
</tbody>
</table>
| Home Health Care        | Prior authorization is required  
  - DME and Supplies are covered per authorization guidelines                                                                                          |
| Hospital Admissions     | Prior authorization is required for all elective admissions  
  Riverside Health must be notified within 24 hours or one business day of any admissions                                     |
| Medical Supplies        | No prior authorization is required for disposable medical supplies                                                                                       |
| Nephrology              | No prior authorization required, including dialysis                                                                                                      |
| Neurology               | No prior authorization is required                                                                                                                         |
| Observation             | No prior authorization is required for observation services  
  Riverside Health must be notified within 24 hours or one business day of any admissions that resulted from observation services |
| Obstetrical Care        | No prior authorization is required  
  Please notify Riverside Health within 24 hours following the first OB visit for referral to case management                                             |
| Occupational Therapy    | Prior authorization is required for adults over 21 years of age.  
  Covered by the State for children under 21 years of age.                                                                                      |
| Oncology                | No prior authorization is required                                                                                                                        |
| Ophthalmology           | No prior authorization is required for out-patient services  
  Services that are considered cosmetic are not covered benefits                                                                                 |
| Orthopedics             | No prior authorization is required                                                                                                                        |
| Out of Area/Out of Network Care | Prior authorization is required except for emergency care and DHMH self-referred services                                                                 |
| Outpatient/Ambulatory Surgery (ASC) | No prior authorization is required                                                                                                                           |
| Pain Management         | No Authorization required:  
  - E&M  
  All other services will require a prior authorization                                                                                          |
| Perinatology            | No prior authorization is required                                                                                                                        |
| Plastic Reconstructive Surgery | Prior authorization is required                                                                                                                                |
| Podiatry                | No prior authorization for Podiatry Services for:  
  Medically necessary services for enrollees younger than 21 years old;  
  Diabetes care services specified in COMAR 10.09.67.24; and  
  Routine foot care for enrollees, 21 years old or older with vascular disease affecting the lower extremities |
<table>
<thead>
<tr>
<th>Service</th>
<th>Prior Authorization Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonology</td>
<td>No prior authorization is required</td>
</tr>
<tr>
<td>Physical Rehabilitation (inpatient)</td>
<td>Prior authorization is required</td>
</tr>
<tr>
<td>Physical Therapy (outpatient)</td>
<td>Prior authorization is required for adults over 21 years of age</td>
</tr>
<tr>
<td>Radiology</td>
<td>See Diagnostic Testing</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>No prior authorization is required</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Prior authorization is required</td>
</tr>
<tr>
<td>Sleep Studies</td>
<td>Prior authorization is required</td>
</tr>
<tr>
<td>Sterilization</td>
<td>No prior authorization is required for outpatient services or services provided in ambulatory surgery center</td>
</tr>
<tr>
<td></td>
<td>- Provider must submit a completed consent form and Medicaid Form (MA-30) for sterilizations</td>
</tr>
<tr>
<td></td>
<td>- Reversal of sterilization is not a covered benefit</td>
</tr>
<tr>
<td>Substance Abuse Services (Outpatient)</td>
<td>Member Self-Refer (no authorization required)</td>
</tr>
<tr>
<td>Urology</td>
<td>No prior authorization is required</td>
</tr>
</tbody>
</table>

**Second Opinions**

If an enrollee 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 enrollee to obtain one outside of our network.

**Utilization Management**

**Inpatient Concurrent Review**

To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record:
- At the hospital when indicated
- Via telephone or fax

We conduct select continued stay reviews daily and review discharge plans. Our Utilization management (UM) clinician will also try to meet with the member and/or family to:
- Discuss any discharge planning needs
- Verify they know the PCP’s name and address

We authorize the covered length of stay one day at a time. Our medical director can make exceptions for severe illness and course of treatment or when it is pre-determined by state law. Examples include:
• ICU, CCU
• C-section or vaginal deliveries

We will communicate approved days and bed level coverage to the hospital for any continued stay. Riverside Health adheres to all notification and turn-around time requirements according to NCQA and COMAR regulations.

Discharge Planning
Riverside Health’s Utilization Management clinician coordinates our members’ discharge planning needs with:
• Hospital utilization review/discharge planning staff
• The attending physician
• The Riverside Health Services department

The attending physician, in concert with our Utilization Management clinician or Health Services Representative, coordinates the member’s follow up care with the member’s PCP. For ongoing care, we work with the provider to plan discharge to an appropriate setting such as:
• Hospice
• Convalescent care
• Home health care program
• Skilled nursing facility
• Member’s home

Case Management Services and Programs
Case management is the coordination of care and services provided to members who have experienced a critical event, have recently been diagnosed with a chronic illness, and have multiple diagnoses or complications that require extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services within plan benefits.

The goal of case management is to help members regain optimum health or improve functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member’s condition; determination of the available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

Disease Management
Riverside Health currently offers 2 disease specific programs: Diabetes and Asthma.

Diabetes
The goal of Riverside Health’s Diabetes Disease Management program is to improve the health outcomes for people with Diabetes. The program uses a multi-faceted approach to achieve the best possible therapeutic outcomes based on assessment of Enrollee needs, ongoing care monitoring, evaluation, and tailored Enrollee and practitioner interventions.
**Asthma**
The goal of Riverside’s Asthma Disease Management program is to raise awareness in member and practitioner populations about the signs and symptoms of Asthma and interventions to control this disease. The program uses a multi-faceted approach to achieve the best possible therapeutic outcomes based on assessment of Enrollee needs, ongoing care monitoring, evaluation, and tailored Enrollee and practitioner interventions.

**Referral for Case/Disease Management**
Riverside’s Case and Disease Management Programs 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. Providers wishing to initiate case/disease management services can either e-mail Health Services (healthservices@myriversidehealth.com) or call 410-779-9359 / 800-730-8543. We are available Monday through Friday from 8 a.m. to 5 p.m. Any voicemail messages received after normal business hours will be addressed the following business day. All referrals to case management must include:

- Name of member
- Date of Birth
- ID number
- Diagnosis
- Patient needs

Providers will receive a response within five (5) business days.

*All programs are voluntary, opt-out, and individualized to the need of the member.*

**Other Population Health-based Services**

- Periodic communication of educational materials targeted specifically to the member’s health status, chronic/complex condition, diet, exercise, and stress management and focused on increasing self-management skills and preventing complications.
- Communication of information to the member and health care practitioner(s) based on data obtained from medical and pharmacy claims, including prescription medication history.
- Outreach to selected members upon discharge from an inpatient facility to home to ensure coordination of follow-up, assistance in obtaining needed durable medical equipment, and assistance accessing services and community resources.
- Assistance to members transitioning from hospital to a post-acute care facility to home by working with providers, members and their families concerning discharge planning, care coordination, and member and family education.
• Assistance with access to behavioral health services, coordinated by Riverside Health that assists in initiating care and accessing behavioral health services. You can access this service by calling 410-779-9359 / 800-730-8543.

Clinical Practice Guidelines
Clinical Practice Guidelines were developed for our providers, as well as our members, to assist with decisions about appropriate health care under special clinical circumstances. The use of these guidelines allows for the measurement of their impact on outcomes and may reduce inter provider variation in diagnosis and treatment.

Riverside Health incorporates the latest scientific basis and expert opinion into these guidelines. The guidelines are updated or revised at a minimum of every two years. Please refer to our website for the most updated versions.

Riverside Formulary
Riverside Health 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 percent of the patients who require treatment with a drug from that pharmacologic or therapeutic class. The drugs listed have been reviewed and approved by Riverside Health’s 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 Riverside Health.

Pharmacy Exception Process
There may be occasions when a non-formulary drug is desired for medical management of a specific patient. In those instances the non-formulary medication may be requested through the Pharmacy Exception Process. Exceptions may be requested by contacting the Plan Medical Director for a peer-to-peer review at 410-779-9359 / 800-730-8543.

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 for members to always use the same pharmacy within the Riverside Health 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 Riverside Health 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.

Select Over the counter (OTC) medications and herbal products listed in Riverside’s drug formulary must be accompanied by a prescription for coverage.
Riverside Health Claims Submission Guidelines

Claims for Riverside Health members may be submitted in one of the following methods:

- Electronically (preferred method)
  - Clearinghouse: EMDEON - PAYOR ID 45281

- Paper using a CMS 1500 or UB-04
  - Mail paper claims to: Riverside Health of Maryland, Inc.
    P.O. Box 1572
    Bowie, MD 20717-1572

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

- Member name and address
- Member ID number
- Place of Services
- Provider Name
- Provider NPI
- Diagnosis (ICD9) code(s) and description(s)
- Applicable CPT/Revenue/HCPCs codes
- Applicable modifier(s)

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

If you would like additional information relative to Riverside Health’s claims submission guidelines, please call our Provider Relations Department at 800-730-8543 or visit our website at www.myriversidehealth.com.

Subrogation (MVA)
Riverside Health 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 Riverside Health, it will be paid normally. If, however, it is later discovered that a third party is liable for the charges Riverside Health will retract any monies paid and send the provider a letter advising them to bill the responsible party.

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

In the context of the Riverside Health Compliance Plan, fraud is considered an act of purposeful deception or misrepresentation committed by any person to gain an unauthorized benefit. Abuse committed by a health care provider means activities that are inconsistent with standard fiscal, business, or medical practices that result in unnecessary cost to a government health care program or other health care plan, or that fail to meet professionally recognized standards for health care. Abuse can also include beneficiary practices that may result in unnecessary cost to the Medicaid program.

The Riverside Health Compliance Plan and associated training is posted on our website at www.myriversidehealth.com. Familiarity with, and adherence to, the plan and completion of training is required of all Riverside Health staff, subcontractors, network providers and their staff.

Audits are performed on a routine, scheduled basis to monitor for compliance with requirements associated with Title XIX Programs, to include documentation practices, the Riverside Health Provider Manual and Provider Agreement. Routine monitoring activity includes comparative data analysis on areas such as service utilization and outcomes. Routine reviews focus on identified high-risk or problem areas, ensuring that providers are eligible to participate in Medicaid, ensuring members are properly enrolled in Medicaid, and ensuring documentation supports submitted claims data.

Riverside Health will perform a minimum level of random reviews in accordance with standards established in collaboration with DHMH, in which a selected universe of beneficiaries will be contacted for interviews and clinical records will be reviewed to identify possible errors or evidence of abuse and/or fraud.

Audits are also performed following the identification of an area of concern which may suggest possible abusive or fraudulent activity. Such referrals may come from internal and external sources, unusual trends in claims or other data, provider self-disclosures, and other ongoing monitoring activity. Riverside Health seeks to ensure the integrity of the Medicaid program by investigating any suspected fraud and abuse. Provider fraud and abuse can include:

- Billing more than once for the same service
- Falsifying records
- Performing inappropriate or unnecessary services
- Billing or charging Medicaid enrollees for covered services
- Provider staff misrepresenting credentials
- Denial of care
- Confidentiality violations
- Any other Provider action that places a Member in jeopardy
- Any other Provider action that violates Federal/State or other applicable regulations

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

Riverside Health provides a toll free access line 24 hours a day, 7 days a week to ensure the immediacy of provider reporting of suspected fraud and abuse. Riverside Health will comply with all state and federal mandatory or statutory regulatory requirements with respect to fraud and abuse. The hotline number is (410) 779-9323. Callers may remain anonymous, if they prefer. However, it is the Riverside Health policy that neither Riverside Health nor the provider may retaliate against anyone who identifies oneself and reports any incidence or suspicion of Medicaid fraud or abuse.

**Non-Discrimination**

Covered Services are provided to Members with the same degree of care and skill as customarily provided to Provider’s patients who are not Members, according to generally accepted standards of Provider practice.

Members and non-Members should be treated equitably.

No discrimination against Members on the basis of race, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, color, national origin, place of residence, health status, source of payment for services, cost or extent of Covered Services required, or any other grounds prohibited by law.

**Medical Records Standards**

Riverside Health has adopted the National Committee for Quality Assurance (NCQA) guidelines for medical record documentation as the required minimal standards for complete and accurate medical record reporting.

1. Each page in the record contains the patient’s name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status.
3. All entries in the medical record contain the author’s identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated on the problem list.
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
9. For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history).
10. The history and physical examination identifies appropriate subjective and objective information pertinent to the patient’s presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnoses are consistent with findings.
13. Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. There is review for under - or overutilization of consultants.
17. If a consultation is requested, there a note from the consultant in the record.
18. Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
19. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
20. Hospital discharge summaries.
21. A list of current medications and dosages.
22. Emergency care received.
23. Documentation, if available, of a member’s executed advance directives.
24. Other aspects of care, including ancillary services.
25. An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).
26. There is evidence that preventive screening and services are offered in accordance with the Riverside Health’s practice guidelines.

**Records Storage and Release of Medical Records**
Providers shall maintain medical records for Riverside Health members for a minimum of ten (10) years after the medical record is made.

Paper medical records shall be located in an office with access restricted to authorized staff; electronic medical records shall be on a computer or other device with appropriate security such as passwords or data encryption.

Members are to be forwarded copies of their medical records upon written request.

**Culturally Competent Care**
Cultural competency in health refers to being aware of cultural differences among diverse racial, ethnic, and other minority groups, respecting those differences and taking steps to apply that knowledge to professional practice. Better communication with patients, families and groups from diverse cultures, improves health outcomes and patient satisfaction.
Members have the right to have services provided in a culturally competent manner with consideration for members with limited knowledge of English, limited reading skills, vision, hearing, and those with diverse cultural and ethnic backgrounds.

Services shall be offered that are sensitive to the differences in race, ethnic background, linguistic group age, gender, lifestyle, education, literacy level, disability, religion, social group or geographic location.

Providers should contact member services for coordination of linguistic services through bilingual staff, telecommunication for the deaf, and use of the language line.

**Primary Care Provider – Panel Reports**

Primary care providers will receive monthly panel reports after the 5th business day of the month via one of the following methods:

- Real time member rosters through the Riverside Health Provider Portal (lookup individual members and print PDF of the full roster)
- Mail or E-mail

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**School Based Health Center Services**

The medical encounter form must be sent by the school based health center within three (3) business days or within the same day if the member requires follow-up care by the PCP within one (1) week of being seen by the school based health center.

See sample encounter form Section IV Addendum 1
SECTION III: HEALTHCHOICE BENEFITS AND SERVICES

Overview

- Riverside Health must provide a complete and comprehensive benefit package that is equivalent to the benefits that are available to Maryland Medicaid enrollees through the Medicaid fee-for-service delivery system. Carve-out services (which are not subject to capitation and are not Riverside Health responsibility) are still available for HealthChoice enrollees. 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 enrollees with medically necessary covered services, or for referring an enrollee 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 enrollee.

- An enrollee 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 enrollees. (See Self-Referred Services Section 1, Page 2)

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

- HealthChoice enrollees 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; and
  - Any other charge up to the fee-for-service limit as approved by the Department.

- Riverside Health does charge co-pays for either brand or generic drugs.

- 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 enrollee cannot pay the co-payment. The enrollee’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 enrollees’ access to needed drugs and related pharmaceutical products by requiring that enrollees use mail-order pharmacy providers.

## Covered Benefits and Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
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<tbody>
<tr>
<td>Audiology Services for Adults</td>
<td>Covered only when part of an inpatient hospital stay</td>
</tr>
<tr>
<td>Blood and Blood Products</td>
<td>Blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin</td>
</tr>
</tbody>
</table>
| Case Management Services                    | Case management services are covered for enrollees 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; and  
  - Individuals with a need for substance abuse services.  
  Children in State supervised care.  
  If warranted, a case manager will be assigned to an enrollee when the results of the initial health screen are received by the MCO.  
  A case manager will perform home visits as necessary as part of Riverside Health case management program, and will have the ability to respond to an enrollee’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 1-888-696-9596 if you have questions about dental benefits |
| Diabetes Care Services                       | Riverside Health covers all medically necessary diabetes care services. We cover diabetes care services for enrollees 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; |
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
</table>
| Diabetes Care Services (continued)          | • 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                           | Enrollees in HealthChoice who suffer from End Stage Renal Disease (ESRD) are eligible for REM. To be REM-eligible on the basis of ESRD, enrollees 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 enrollees needing dialysis treatment who are enrolled in Riverside Health, dialysis services are covered, either through participating providers or, at the enrollee’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 enrollee’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 enrollee.  
- 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 enrollee. We pay for any durable medical equipment authorized for enrollees even if delivery of the item occurs within 90 days after the member’s disenrollment from Riverside Health, as long as the member remains Medicaid eligible during the 90-day time period.  
- Speech augmenting devises are paid for by the State on a fee-for service basis. |
| Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services | For enrollees 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
<table>
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<tr>
<th>Benefit</th>
<th>Description</th>
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<tbody>
<tr>
<td>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services (continued)</td>
<td>basis of medical necessity, including:</td>
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<td>- Chiropractic services;</td>
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<td>- Nutrition counseling;</td>
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<td>- Audiological screening when performed by a PCP;</td>
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<td>- Private duty nursing;</td>
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<td>- Durable medical equipment including assistive devices; and</td>
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<td>- Any other benefit listed in this section.</td>
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<td></td>
<td>- 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).</td>
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<tr>
<td>Family Planning Services</td>
<td>Comprehensive family planning services are covered, including:</td>
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<td>- Office visits for family planning services;</td>
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<td>- Laboratory tests including pap smears;</td>
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<td>- Contraceptive devices;</td>
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<td>- Voluntary sterilization</td>
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<td>Home Health Services</td>
<td>Home health services are covered when the enrollee’s PCP or attending physician certifies that the services are necessary on a part-time, intermittent basis by an enrollee who requires home visits. Covered home health services are delivered in the enrollee’s home and include:</td>
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<td>- Skilled nursing services including supervisory visits;</td>
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<td>- Home health aide services (including biweekly supervisory visits by a registered nurse in the enrollee’s home, with observation of aide’s delivery of services to enrollee at least every second visit);</td>
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<td>- Physical therapy services;</td>
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<tr>
<td></td>
<td>- Occupational therapy services;</td>
</tr>
<tr>
<td></td>
<td>- Speech pathology services;</td>
</tr>
<tr>
<td></td>
<td>- Medical supplies used in a home health visit.</td>
</tr>
<tr>
<td>Hospice Care Services</td>
<td>Hospice care services are covered for enrollees 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 enrollees (or patients applying for Medicaid coverage) as soon as possible after they enter hospice care about the MCOs with whom they contract so that enrollees can make an informed choice.</td>
</tr>
<tr>
<td></td>
<td>We do not require a hospice care enrollee to change his/her out of network hospice provider to an in-network hospice provider. Hospice providers should make enrollees aware of the option to change MCOs. DHMH will allow new enrollees 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 enrollee does not change their MCO, then the MCO, which the new enrollee is currently enrolled must pay the out-of-network hospice provider.</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>Inpatient hospital services are covered. For special rules for length of stay for childbirth (See Page 18)</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>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</td>
</tr>
</tbody>
</table>
### Benefit Description

**Benefit**: in treatment of HIV/AIDS are reimbursed directly by the Department and must be rendered by a Department approved provider and be medically necessary

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term Care Facility Services/Nursing Facility Services</td>
<td>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 Riverside Health, subject to specific rules. When an enrollee is transferred to a long-term care facility and the length of the enrollee’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 thirty 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 enrollee’s disenrollment are satisfied. In order for an enrollee to be disenrolled from Riverside Health based on a long-term care facility admission, all of the following must first occur:</td>
</tr>
<tr>
<td></td>
<td>• 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).</td>
</tr>
<tr>
<td></td>
<td>• DHMH must determine that the enrollee’s long-term care facility admission was medically necessary in accordance with the State’s criteria.</td>
</tr>
<tr>
<td></td>
<td>• The enrollee’s length of stay must exceed 30 consecutive days.</td>
</tr>
<tr>
<td></td>
<td>• We must file an application for disenrollment with DHMH, including documentation of the enrollee’s medical and utilization history, if requested.</td>
</tr>
<tr>
<td></td>
<td>Once an individual has been disenrolled from Riverside Health, 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 enrollee 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 Riverside Health covered 30 continuous days in a long term care facility as long as the enrollee 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 enrollee 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 an enrollee 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 enrollee is likely to require less than 30 days of NF services. If an enrollee is not exempted, complete the ID Screen to identify whether the enrollee screens positive for mental illness or mental retardation. If the enrollee 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. An enrollee admitted to an Intermediate Care Facility - Mental Retardation (ICF-MR) is disenrolled from Riverside Health immediately upon admission to the facility, and we retain no responsibility for the enrollee’s care. If we place an enrollee in a licensed nursing facility that is not a Maryland Medical</td>
</tr>
</tbody>
</table>
## Benefit Services/Nursing Facility Services (continued)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term Care 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 an enrollee 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 enrollees hospitalized for an acute condition within the first 3 days not to exceed 15 days per single acute visit.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Services Medically necessary outpatient hospital services are covered</td>
<td></td>
</tr>
<tr>
<td>Oxygen and Related Respiratory Equipment Oxygen and related respiratory equipment are covered</td>
<td></td>
</tr>
<tr>
<td>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 enrollee’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. If the service is denied, Riverside Health will notify the prescriber and the enrollee 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 enrollee has legitimately self-referred (if provided on-site), or by an emergency medical provider are covered, including:</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Services (continued)</td>
<td>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; Nonlegend ferrous sulfate oral preparations; Nonlegend chewable ferrous salt tablets when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in formulation, for enrollees under age 12; Formulas for genetic abnormalities; Medical supplies for compounding prescriptions for home intravenous therapy;</td>
</tr>
<tr>
<td>Benefit</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| **Medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for an enrollee by a qualifying provider.**
| **Most Mental health drugs are on SMHS formulary and are to be paid by SMHS.**
| **Most HIV/AIDS drugs are paid directly by the State.**

Riverside Health’s drug utilization review program is subject to review and approval by DHMH, and is coordinated with the drug utilization review program of the Specialty Mental Health Service 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;
- 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.

Riverside Health shall clearly define and specify referral requirements to all providers.

An enrollee’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 effect a permanent cure.

**Podiatry Services**

Riverside Health provides its enrollees medically necessary podiatry services as follows:

- For enrollees younger than 21 years old
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Services</strong></td>
<td>Primary care is generally received through an enrollee’s PCP, who acts as a</td>
</tr>
<tr>
<td></td>
<td>coordinator of care, and has the responsibility to provide accessible,</td>
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<tr>
<td></td>
<td>comprehensive, and coordinated health care services covering the full range</td>
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<tr>
<td></td>
<td>of benefits for which an enrollee is eligible. In some cases, enrollees will</td>
</tr>
<tr>
<td></td>
<td>opt to access certain primary care services by self-referral to providers</td>
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<tr>
<td></td>
<td>other than their PCPs, for example, school-based health centers. Primary</td>
</tr>
<tr>
<td></td>
<td>care services include:</td>
</tr>
<tr>
<td></td>
<td>• Addressing the enrollee’s general health needs;</td>
</tr>
<tr>
<td></td>
<td>• Coordination of the enrollee’s health care;</td>
</tr>
<tr>
<td></td>
<td>• Disease prevention and promotion and maintenance of health;</td>
</tr>
<tr>
<td></td>
<td>• Treatment of illness;</td>
</tr>
<tr>
<td></td>
<td>• Maintenance of the enrollees’ health records; and</td>
</tr>
<tr>
<td></td>
<td>• Referral for specialty care.</td>
</tr>
<tr>
<td></td>
<td>For female enrollees, if the enrollee’s PCP is not a women’s health</td>
</tr>
<tr>
<td></td>
<td>specialist she may see a women’s health specialist within Riverside Health,</td>
</tr>
<tr>
<td></td>
<td>without a referral, for covered services necessary to provide women’s</td>
</tr>
<tr>
<td></td>
<td>routine and preventive health care services.</td>
</tr>
<tr>
<td><strong>Primary Mental Health Services</strong></td>
<td>We cover primary mental health services required by enrollees, including</td>
</tr>
<tr>
<td></td>
<td>clinical evaluation and assessment, provision of primary mental health</td>
</tr>
<tr>
<td></td>
<td>services, and/or referral for additional services, as appropriate.</td>
</tr>
<tr>
<td></td>
<td>The PCP of an enrollee requiring mental health services may elect to treat</td>
</tr>
<tr>
<td></td>
<td>the enrollee, if the treatment falls within the scope of the PCP’s practice,</td>
</tr>
<tr>
<td></td>
<td>training, and expertise. Neither the PCP nor Riverside Health may bill the</td>
</tr>
<tr>
<td></td>
<td>Public Mental Health System (PMHS) for the provision of such services</td>
</tr>
<tr>
<td></td>
<td>because these services are included in the HealthChoice capitation rates.</td>
</tr>
<tr>
<td></td>
<td>When, in the PCP’s judgment, an enrollee’s need for mental health treatment</td>
</tr>
<tr>
<td></td>
<td>cannot be adequately addressed by primary mental health services provided</td>
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<tr>
<td></td>
<td>by the PCP, the PCP should, after determining the enrollee’s eligibility</td>
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<tr>
<td></td>
<td>(based on probable diagnosis), refer the enrollee to the SMHS for specialty</td>
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<tr>
<td></td>
<td>mental health services. (This process is described in Section IV)</td>
</tr>
<tr>
<td><strong>Rehabilitative Services</strong></td>
<td>Rehabilitative services including medically necessary physical therapy,</td>
</tr>
<tr>
<td></td>
<td>speech therapy, and occupational therapy for adults are covered. For enrollees</td>
</tr>
<tr>
<td></td>
<td>under age 21, rehabilitative services are covered by Riverside Health only</td>
</tr>
<tr>
<td></td>
<td>if part of a home health visit or inpatient hospital stay. All other</td>
</tr>
<tr>
<td></td>
<td>rehabilitative services for enrollees under age 21 should be billed</td>
</tr>
<tr>
<td></td>
<td>fee-for-service to the Department.</td>
</tr>
<tr>
<td><strong>Second Opinions</strong></td>
<td>If an enrollee requests one, we will provide for a second opinion from a</td>
</tr>
<tr>
<td></td>
<td>qualified health care professional within our network. If necessary we will</td>
</tr>
<tr>
<td></td>
<td>arrange for the enrollee to obtain one outside of our network.</td>
</tr>
<tr>
<td><strong>Substance Abuse Treatment  Services</strong></td>
<td>Substance abuse treatment services are covered. (See Page 21)</td>
</tr>
<tr>
<td></td>
<td><strong>Transplants</strong> Medically necessary transplants are covered</td>
</tr>
<tr>
<td><strong>Vision Care Services</strong></td>
<td>Medically necessary vision care services are covered. Riverside Health is</td>
</tr>
<tr>
<td></td>
<td>responsible to provide at a minimum:</td>
</tr>
<tr>
<td>Benefit</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>• One eye examination every 2 years for enrollees age 21 or older; or&lt;br&gt;• For enrollees 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</td>
</tr>
</tbody>
</table>

**Benefit Limitations**

The following services are not covered under HealthChoice, and are therefore not covered benefits under Riverside Health.

- Services which 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, unless pregnant. (Riverside Health offers limited dental coverage for adults as an optional benefit. See Section 2, Page 15)
- 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 an enrollee 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 enrollee 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 enrollee 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 is available.

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

• Reversal of voluntary sterilization procedure.

• Services performed before the effective date of the enrollee’s coverage.

• Transportation services that are provided through Local Health Departments. Riverside Health will assist enrollees to secure non-emergency transportation through their local Health Departments or provide non-emergent transportation directly if it is not accessible (see page 38). Additionally, we provide non-emergency transportation to access a covered service if we choose to provide the service at a location that is outside of the closest county in which the service is available. The following is a list of the transportation contact numbers for each county:

<table>
<thead>
<tr>
<th>County</th>
<th>Telephone number to Call</th>
<th>County</th>
<th>Telephone number to Call</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegany</td>
<td>Van Trans Inc. 301-722-2770</td>
<td>Allegany</td>
<td>Allegany Ambulance 301-689-1113</td>
</tr>
<tr>
<td>Anne Arundel</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

46
<table>
<thead>
<tr>
<th>County</th>
<th>Organization</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<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>
</tr>
<tr>
<td></td>
<td>(Facilities only)</td>
<td>410-396-6665</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>Veolia Transportation</td>
<td>410-783-2465</td>
</tr>
<tr>
<td></td>
<td></td>
<td>410-887-2828</td>
</tr>
<tr>
<td>Calvert</td>
<td></td>
<td>410-535-5400</td>
</tr>
<tr>
<td>Caroline</td>
<td></td>
<td>410-479-8030</td>
</tr>
<tr>
<td>Carroll</td>
<td>Butler Medical Transport</td>
<td>888-602-4007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>410-602-4007</td>
</tr>
<tr>
<td>Cecil</td>
<td></td>
<td>410-996-5550</td>
</tr>
<tr>
<td>Charles</td>
<td></td>
<td>301-609-7917</td>
</tr>
<tr>
<td>Dorchester</td>
<td></td>
<td>410-901-2426</td>
</tr>
<tr>
<td>Frederick</td>
<td>Garrett Community Action</td>
<td>301-334-9431</td>
</tr>
<tr>
<td></td>
<td></td>
<td>410-638-1671</td>
</tr>
<tr>
<td>Garrett</td>
<td>Montgomery Co Dept of Public Works &amp; Transit</td>
<td>240-777-5890</td>
</tr>
<tr>
<td>Harford</td>
<td></td>
<td>410-638-1671</td>
</tr>
<tr>
<td>Howard</td>
<td></td>
<td>410-313-6300</td>
</tr>
<tr>
<td>Kent</td>
<td></td>
<td>410-778-7025</td>
</tr>
<tr>
<td>Montgomery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prince George’s</td>
<td></td>
<td>301-856-9555</td>
</tr>
<tr>
<td>Queen Anne’s</td>
<td>QA Co Dept of Aging</td>
<td>410-758-0720</td>
</tr>
<tr>
<td>St. Mary’s</td>
<td></td>
<td>301-475-4296</td>
</tr>
<tr>
<td>Somerset</td>
<td></td>
<td>443-523-1722</td>
</tr>
<tr>
<td>Talbot</td>
<td></td>
<td>410-819-5600</td>
</tr>
<tr>
<td>Washington</td>
<td></td>
<td>240-313-3264</td>
</tr>
<tr>
<td>Wicomico</td>
<td></td>
<td>410-548-5142</td>
</tr>
<tr>
<td>Worcester</td>
<td></td>
<td>410-632-0092 or 0093</td>
</tr>
</tbody>
</table>

- Therapeutic footwear other than for an enrollee who qualifies for diabetes care services or for an enrollee who is younger than 21 years old.
Medicaid Covered Services That Are Not Riverside Health’s Responsibility

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

- Dental services for children and pregnant women of any age

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

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

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

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

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

- Specialty mental health services. (See Section IV)

- All services to individuals enrolled in the Rare and Expensive Case Management Program. (See Section V)

- Service provided after the thirtieth day of an enrollee’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 Riverside Health receiving the Department’s 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.

- 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.

- Speech augmenting devices.
Self-Referral Services
Enrollees can elect to receive certain covered services from out-of-plan providers. Riverside Health will cover these pursuant to COMAR 10.09.67.28. The services that an enrollee has the right to access on a self-referral basis include:

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

- Certain school-based healthcare 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 Riverside Health 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 an enrollee diagnosed with HIV or AIDS.

- Continued obstetric care with her pre-established provider for a new pregnant enrollee.

- 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 Riverside Health for review and approval within 30 days of enrollment (For additional information, see Page 3).

- 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 and ADAA certified provider and ASAM criteria is met.

- Services performed at a birthing center, including an out of state provider.
## Optional Services Provided by Riverside Health

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>WHAT IT IS</th>
<th>HOW WILL THE SERVICE BE PROVIDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADULT DENTAL</td>
<td>Riverside Health will provide preventative and restorative dental benefits to all adult eligible members with an annual cap of $250 per member. The benefit will include exams, x-rays, and extractions.</td>
<td>The service will be administered through DentaQuest, a national dental benefits administrator and their statewide network of dentists.</td>
</tr>
<tr>
<td>ADULT VISION</td>
<td>Riverside Health will provide one pair of glasses every two years to all Adult eligible members. The mandatory HealthChoice benefit allows for adults to receive a vision exam every two years. Riverside will provide for one pair of glasses in the event the exam outlines the need for glasses. The cost of eyeglasses frames will be limited to $125 per pair.</td>
<td>The service will be administered through Block Vision, a national vision services administrator and their statewide network of optometrists and ophthalmologists.</td>
</tr>
<tr>
<td>ACUPUNCTURE</td>
<td>Riverside Health will provide acupuncture services to members diagnosed with a substance abuse addiction. The benefit will be limited to 2 treatments per week up to 16 treatments per year.</td>
<td>The service will be provided by a limited number of contracted providers in limited service areas.</td>
</tr>
<tr>
<td>ENHANCED TRANSPORTATION</td>
<td>Riverside Health will provide non-emergency medical transportation services exclusively to facilitate access to medical appointments, when these services cannot be provided through the local health department.</td>
<td>The service will be provided by Medical Transportation Management, Inc.</td>
</tr>
<tr>
<td>Over the Counter Medications and Supplies (OTC)</td>
<td>Riverside Health will provide members with a $15 per quarter OTC benefit for such items as aspirin, band aids, cold suppressants, ointments, vitamins and herbal supplements. These items must be prescribed by a physician.</td>
<td>The service will be provided by Riverside Health’s pharmacy benefit manager, CVS Caremark, a national PBM. All members will present their prescription for service to the participating network pharmacy to receive their OTC item(s). CVS Caremark will reimburse the pharmacy for service and will track each member’s quarterly expenditure, not to exceed $15.</td>
</tr>
</tbody>
</table>
SECTION IV:
SPECIALTY 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 enrollee’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.maryland.gov/mha

Description
In the State of Maryland, the system responsible for the delivering of specialty mental health services to Medicaid enrollees is the Public Mental Health System (PMHS). The PMHS will deliver all specialty mental health services to enrollees 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.maryland.gov/mha/SitePages/csa.aspx
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 enrollees, 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 enrollee access to services.

• Measure the quality of the services rendered.

• Handle grievances and appeals, in accordance with COMAR.

Role of the Administrative Service Organization (ASO)

The ASO:

• Verifies the eligibility of enrollees.

• 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 enrollees at 1-800-888-1965. Access for providers is maintained from 8:00 am – 6:00 pm Monday through Friday at 1-800-888-1965.

• Conducts annual provider and enrollee 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, Riverside Health or our PCPs do have the responsibility to refer eligible enrollees to the PMHS when specialty mental health services are needed.

• An enrollee with a probable diagnosis of a mental disorder is eligible for referral to the SMHS by the PCP or Riverside Health if the following conditions are met:

  ▪ The enrollee’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 Riverside Health determines that primary mental health services provided by the PCP are insufficient to address the enrollee’s mental health treatment needs.

- A mental health professional functioning as the SMHS utilization review (UR) agent will accept preauthorization 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 enrollee 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 enrollee, to determine whether an alternative service or a service of alternate duration is appropriate.

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

- With the enrollee’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 enrollee’s living situation or cause severe disruption to an enrollee with serious and persistent mental illness or serious emotional disturbance.

**Referring an Enrollee to the SMHS through a Toll-Free Help Line: 1-800-888-1965**

The ASO’s toll-free number is available 24 hours a day, 7 days a week and is staffed by qualified mental health professional called Care Managers.

Enrollees are able to access the ASO directly or through assistance from Riverside Health, 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 them self or others. The enrollee or the person making the call may state or imply that the enrollee 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 an enrollee or the person making the call who states or implies that the enrollee may do harm to them self or others if help is not received soon. The caller states or implies the enrollee’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 enrollee 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 enrollee 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 enrollee or caller feels that the enrollee is in no immediate harm, but requires an assessment and, probably mental health services. The PMHS protocols require that enrollees 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**

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<thead>
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<th>Code Range</th>
<th>Code Range</th>
<th>Code</th>
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<td>307.3</td>
<td>313.89 – 314.9</td>
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SECTION V:
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, an enrollee must have one or more of the diagnoses specified in the Rare and Expensive Disease List at the end of this section. The enrollees may elect to enroll in the REM Program, or to remain in Riverside Health if the Department agrees that it is medically appropriate. REM participants are eligible for fee-for-service benefits currently offered to Medicaid-eligible enrollees 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:

• 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 determine the enrollee’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 enrollee and referral source.

If the Intake nurse determines that the enrollee has a REM-qualifying diagnosis, the nurse approves the enrollee 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 enrollee. If the PCP will continue providing services, the Intake Unit then calls the enrollee to notify of the enrollment approval, briefly explain the program, and give the enrollee an opportunity to refuse REM enrollment. If enrollment is refused, the member remains...
in the MCO. At the time of enrollee notification, The Intake Unit also ascertains if the enrollee 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 enrollee’s care until the enrollee is actually enrolled in the REM program. If the enrollee does not meet the REM criteria, the enrollee will remain enrolled in Riverside Health.

For questions or to request a REM Referral Form, please call telephone number 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 May 2010

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<th>Disease</th>
<th>Age Group</th>
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<td>Disturbances of sulphur-bearing amino-acid metabolism</td>
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<td>Histidinemia</td>
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<td>Imidazole aminoaciduria</td>
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<td>Hyperglycinemia, Hyperlysinemia</td>
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<td>Saccharopinuria</td>
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<td>Other disturbances of metabolism of glycine, threonine, serine, glutamine, and lysine</td>
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<td>Other specified disorders of amino-acid metabolism: Alaninemia, Ethanolaminuria, Glycoprolinuria, Hydroxyprolinemia, Hyperprolinemia, Iminoacidopathy, Prolinemia, Prolinuria, Sarcosinemia</td>
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SECTION VI: DHMH Quality Improvement and MCO Oversight Activities

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 enrollee selects an MCO to assure that the MCO is alerted to immediate health needs, e.g., prenatal care service needs.
- A complaint, grievance and appeal process administered by Department staff.
- A complaint, grievance and appeal process administered by Riverside Health.
- 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 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.

MCO Member Hotline
Riverside Health maintains a Member Services unit that operates a member services hotline Monday through Friday from 8:00am through 5:00pm. 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 Department and consumer services hotline to obtain information and assistance. The number for members is 1-800-730-8530 and for providers is 1-800-730-8543.

MCO Member Complaint Policy and Procedures
Riverside Health has written complaint policies and procedures whereby an enrollee who is dissatisfied with the MCO or its network may seek recourse verbally or in writing from the HealthChoice Enrollee Help Line staff. Riverside Health must submit its written internal complaint policy and procedures to the Department for its approval.

Riverside Health’s internal complaint materials are developed in a culturally sensitive manner, at a suitable reading comprehension level, and in the enrollee's native tongue if the enrollee is a member of a substantial minority. Riverside Health delivers a copy of its complaint policy and procedures to each new enrollee at the time of initial enrollment, and at any time upon an enrollee's request.

Riverside Health 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 5 days and administrative grievances within 30 days. In addition, the written procedures:

1. Require documentation of the substance of the complaints and steps taken to resolve;
2. Include participation by the provider, if appropriate;
3. Allow participation by the ombudsman, if appropriate;
4. Ensure the participation of individuals within the MCO who have the authority to require corrective action;
5. Include a documented procedure for written notification on the outcome of our determination;
6. Include a procedure for immediate notice to the Department of all disputed denials of benefits or services in emergency medical situations;
7. Include a procedure for notice to the enrollee through an Adverse Action Letter that meets the approval of the Department of all disputed denials, reductions, suspensions, or terminations of services or benefits;
8. Include an appeal process which provides, at its final level, an opportunity for the enrollee to be heard by our Chief Executive Officer, or their designee;
9. Include a documented procedure for reporting of all complaints received by us to appropriate parties; and
10. 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 enrollee for making a complaint against us or the Department.

**Appeals**

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 that 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 enrollee’s condition or disease
- Not use the same MCO staff to review the appeal who denied the original request for service
- Make a decision about administrative appeals within 30 days

If the member’s doctor or Riverside Health 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 his or her appeal within 3 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 he or she was already receiving, the member may be able to continue to receive the service while we review the appeal.
The member should contact us at 1-800-730-8530, if he or she would like to continue receiving services while the appeal is reviewed. If the member does not win the appeal, he or she may have to pay for the services that were received while the appeal was being reviewed.

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

**Continuity of Benefits**

Pending the outcome of the appeal, the provider may request an extension of benefits if:

- The appeal was filed within 10 days of the mailing of the denial letter; or the intended effective date of the proposed action.
- The appeal involves the termination, suspension or reduction of a previously authorized service,
- The services were ordered by an in-network provider; and
- The authorization period has not expired.

If benefits have been reinstated or continued during the appeal, they shall continue until:

- The provider withdraws the appeal,
- The member does not request a Fair Hearing within 10 days from when Riverside Health mailed the adverse decision,
- A state fair hearing decision that is adverse to the member is made, or
- The authorization expires or service limits are met.

**Grievances**

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

If the member’s grievance is:

- About an urgent medical problem, 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 he or she needs help filing a complaint, the member can call 1-800-730-8543.
**MCO Provider Complaint Process**

Riverside Health wants to have a positive working relationship with our all of health care providers. We recognize that we may not always be able to achieve this goal and want to hear from our providers when they are dissatisfied with an administrative process within Riverside Health. A Riverside Health provider may file a grievance at any time in writing or by calling any Riverside Health staff member.

Grievances are managed by the Riverside Health Quality and Performance Improvement Department. Grievances are accepted verbally or in writing by any Riverside Health staff person and then routed to the Quality Department. All grievances are responded to in writing; acknowledged within 5 business days of receipt; investigated by the department that is the subject of the grievance, and resolved within 30 calendar days of receipt. All provider grievances are logged, categorized and on completion, are evaluated by the Grievance and Appeal Committee for patterns and/or trends.

If a provider is not satisfied with the actions taken by Riverside Health in addressing the grievance, they may contact the State’s Complaint Resolution Unit at 1-800-284-4510 for further action.

**MCO Provider Claims Appeal Process**

A provider may appeal a decision by Riverside Health to deny or partially deny payment of services rendered. An appeal must be filed, with the written consent of the member, within 180 days of the date of the denial of payment. A provider appeal must be in writing.

Riverside Health will acknowledge an appeal in writing within 5 business days of receipt. Riverside Health will resolve an appeal in writing within 30 days of receipt. Riverside Health will provide a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. Riverside Health will permit the provider the opportunity before and during the appeal process to examine the appeals case file including medical records and any other documents and records. When reviewing the appeal, Riverside Health will consider a full investigation of the substance of the appeal including any clinical aspects. Riverside Health will appoint a new reviewer, who was not involved with the initial determination, is not a subordinate of any person involved in the initial determination and is of the same or similar specialty as typically treats the medical condition or performs the procedure.

**Notification of the Outcome of Appeal**

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

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

The provider must notify Riverside Health in writing of their request for a second level appeal within 15 business days of the date of the letter noting the outcome of the appeal. Riverside Health will acknowledge the request for a second level appeal in writing within 5 days of receipt. A meeting between the Riverside Health Chief Executive Officer or designee, the provider and a provider who was not involved in the case is scheduled. Riverside Health appoints a new reviewer who was not involved with the initial determination, is not a subordinate of any person involved in the initial appeal determination and is of the same or similar specialty as typically treats the medical condition or performs the procedure. The appellant is notified of the selection of a reviewer. The selected reviewer receives all documentation used in the initial appeal process for review. During the informal meeting the appellant, the reviewer and the Chief Executive Officer review the evidence and a determination is made by the reviewer. The appellant is notified in writing of the decision. This is the final level of appeal.

Riverside Health will pay a claim within 30 days of the appeal decision when a claim denial is overturned.

Riverside Health will not take punitive action against a provider for utilizing the provider appeal process.

DHMH Quality Oversight: Complaint and Appeal Processes

The HealthChoice and Acute Care Administration operate the central complaint investigation process. The Member 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 AM to 5:30 PM. The toll free telephone number is: 1-800-284-4510 or TDD at 1-800-735-2258 for the hearing impaired.

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

- Direct enrollees 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 1-800-766-8692; TDD 1-800-735-2258. 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 AM to 5:30 PM and has the capability to address enrollees 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 Riverside Health 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/ACCU 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 Unit 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 1-888-
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. An 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 an 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 3
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
Riverside Health’s Quality Management

Overview
This is the initial Quality Assurance Plan (QAP) for Riverside Health; a managed care organization founded to meet the healthcare needs of Maryland’s HealthChoice members. It is the goal of Riverside Health to provide a quality and performance improvement program that is continuous, systematic, and data driven and designed to monitor, measure, evaluate, and improve the quality of health care services delivered to HealthChoice members. In collaboration with the State of Maryland (Department), CMS and Delmarva, the External Quality Review Organization (EQRO), Riverside Health will operationalize a robust and meaningful quality and performance improvement program that is consistent with access and quality standards for members, including those with special health needs, and complies with all applicable federal laws and laws of the State of Maryland.

Scope
Quality is the core concept that drives each department at Riverside Health. The organization has developed process measures to assure optimal performance for each department and will begin to systematically collect data to measure outcomes. This includes, but is not limited to, Health Services, Provider Relations, Credentialing, Compliance, Member Services, Appeals and Grievance, and Claims. Special attention is given to high volume, high-risk areas of care and service for our population and to all facets of care and service for the special needs populations. Health promotion and health management activities are also an integral part of the Quality Improvement Program (QIP).

The scope of the quality plan includes the following:
- Measure performance against key monitors for quality improvement (clinical and non-clinical) as identified by the Quality Improvement Program (QIP) and activities identified in the Quality Improvement Work Plan.
- Review of the quality and utilization of clinical care and service, including inpatient and outpatient care provided by hospitals, practitioners, health care professionals and ancillary providers.
- Ensure compliance with applicable regulatory and contractual requirements including state and federal regulations.
- Analyze, identify and address continuity and coordination of care.
- Analyze, identify and address areas of under and over-utilization.
- Monitor, identify and investigate potential Quality of Care/Quality of Service (QOC/QOS) issues. Implement improvement actions as needed.
- Analyze, identify and address areas that will improve patient safety.
- Analyze, identify and address member and practitioner satisfaction information.
- Analyze, identify and address access to and availability of care, including Special Needs Population.
- Solicit member and provider input on performance and QI activities.

Responsibility and Accountability
The Board of Directors (BOD) of Riverside Health has ultimate accountability for the development and implementation of the quality program. The governing body of Riverside Health is the Board of Directors. The Board’s participation with quality issues is not direct. The Quality improvement committee structure is comprised of senior management leadership. The BOD has delegated the day-to-day oversight of the program to the Quality Improvement Committee. The clinical program is under the direction of the Medical Director, a Maryland licensed board certified physician, who is responsible for its implementation. The Quality Improvement Committee is responsible to provide QIC minutes, written reports from the QIC and the QIC’s subcommittees at least annually. The Utilization Management Program is responsible to the Board through the Quality Improvement Committee and is under the direction of the Riverside Health Medical Director who is responsible for decision-making. The Vice President of Health Services oversees the day-to-day function of the Utilization Management Department. The Board approves all documents pertaining to the quality program including the Quality Assurance Plan (QAP), annual Quality Improvement (QI) evaluation of the QAP and the annual QI Work Plan.

**Monitoring**

The monitoring of quality indicators is designed to reveal trends and performance opportunities in specific areas and facilitate plan-wide improvement. To this end, a variety of care and service indicators to monitor is derived from as many sources as appropriate. The quality indicators are measurable, based on reasonable research, and use current and accepted quality methodologies. Examples of monitoring indicators may include: tracking and trending of inpatient or outpatient acute or chronic conditions, access performance measurements, or unique specific indicators as identified from local epidemiology or demographics.

a. QA Studies- Using the NCQA approved QIA methodology and form
b. Trending of clinical and service indicators and other performance data, including HEDIS® and CAHPS® results and or inpatient, outpatient or disease manage chronic conditions
   i. The effectiveness of the plan’s clinical improvement activities are most often assessed through HEDIS® Effectiveness of Care Measures and the Value Based Purchasing Measures. However, Riverside Health may use other measurement methodologies, as appropriate, when as unique indicator is selected for improvement
c. Demonstrated improvement in quality
d. Areas of Deficiency
e. Recommendations for Corrective Action Plans (CAPs)
f. An evaluation of overall effectiveness

Quality Studies and other monitoring quality indicators will be added to the QI Work Plan and presented to the PAC, and reported to the QIC.

**Goals and Objectives – Quality Assessment Plan (QAP)**

Riverside Health strives to continuously improve the care and service provided by our health care delivery system. Riverside Health's Maryland Medicaid Quality Assessment Plan (QAP) the overarching goals for the quality plan include:

- The Systematic improvement in the quality of health care
- Respect for the patient-physician relationship
• Member-focused innovation
• Compassion for people
• Honesty and integrity

For the first year of operation, Riverside Health has established the following more specific goals and objectives:

Goal: Provide effective monitoring and evaluation of patient care and services to ensure that care provided by health plan practitioners/providers meets the requirements of good medical practice and is positively perceived by health plan members and health care professionals.

Goal: Evaluate and disseminate clinical and preventive practice guidelines. Monitor performance of practitioners and providers against Evidence-based Medicine. Develop guidelines for quality improvement activities (e.g. access and availability, credentialing/recredentialing, peer review, etc.).

Goal: Assure timely access to and availability of appropriate quality services for the population served
• Objective: Ensure qualified individuals and organizations including those with the qualifications and experience appropriate to service members with special needs provide services.
• Objective: Ensure the safety of all members in all treatment settings.
• Objective: Improve the health service delivery system by implementing policies and work processes to conduct access, availability, quality, utilization, care coordination, credentialing, compliance and fiscal monitoring using defined standards.
• Objective: Establish outcome measures and begin to collect data to improve the medical and mental health of individuals served by Riverside Health.

Goal: Encourage and mentor providers and plan staff in the implementation of the quality program and the methods to ensure compliance with Riverside Health policies and guidelines and support a provider and community culture of quality improvement.
• Objective: Implement programs that support all Riverside Health staff in application of quality methodology through structured education, training and mentoring.
• Objective: Establish performance measures tied to practitioner and provider reimbursement.
• Objective: Implement a rigorous delegation oversight process to include pre-delegation review, structured oversight and reporting and corrective actions as needed.
• Objective: Provide adequate infrastructure and resources to support a quality culture.

Goal: Ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up. Identify and monitor important aspects of care and services, quality indicators, problems, and concerns about health care services provided to members. Implement and conduct a comprehensive Quality Improvement Program. Recognize that opportunities for improvement are unlimited.

Goal: Provide ongoing feedback to health plan members and practitioners regarding the measurement and outcome of quality improvement (clinical and non-clinical) activities. Support
re-measurement of effectiveness and continued development and implementation of improvement interventions.

Goal: Assure community involvement in maintaining and improving member health through a comprehensive community/provider partnership.

- Implement a structured education program for staff, practitioners/providers, members, and the community in best practices/evidence based practices.
- Establish the processes for coordination and collaboration of care between providers, Riverside Health and the members we serve.

Initiatives

Riverside Heath’s quality plan plays a key role in infusing a quality mindset to the following functions and concepts within Riverside Health:

- To promote and incorporate quality into Riverside Health’s organizational structure and processes.
  1. Facilitate a partnership between members; practitioners, providers and health plan staff for the continuous improvement of quality health care delivery.
  2. Clearly define roles, responsibilities and accountability for the quality program.
  3. Continuously improve communication and education in support of these efforts.
  4. Consider and facilitate achievement of public health goals in the areas of health promotion and early detection and treatment.

- Provide effective monitoring and evaluation of patient care and services that ensures care provided by Riverside Health practitioners/providers meets the requirements of good medical practice and is positively perceived by health plan members and health care professionals.
  1. Evaluate and disseminate clinical and preventive practice guidelines.
  3. Develop guidelines for quality improvement activities (e.g. access and availability, credentialing/re-credentialing, peer review, etc.).
  4. Survey Riverside’s members and practitioners’ satisfaction with the quality of care and services provided.
  5. Complete Performance Improvement Projects for Medicaid specific QI projects
  6. Develop, define, and maintain data systems to support quality improvement activities and encourage data-driven decision-making.
  7. Provide disease management programs that improve the quality of life for chronically ill members.

- To ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up.
1. Identify and monitor important aspects of care and services, quality indicators, problems, and concerns about health care services provided to members.
2. Implement and conduct a comprehensive Quality and Performance Improvement Program.
3. Recognize that opportunities for improvement are unlimited.
4. Provide ongoing feedback to Riverside Health members and practitioners regarding the measurement and outcome of quality improvement (clinical and non-clinical) activities.
5. Support re-measurement of effectiveness and continued development and implementation of improvement interventions.

- To coordinate quality improvement, risk management and patient safety activities.
  1. Aggregate and use data to develop quality improvement activities.
  2. Provide a regular means by which risk management is included in the development of quality improvement initiatives.
  3. Identify, develop and monitor key aspects of patient safety

- To maintain compliance with local, state and federal regulatory requirements and accreditation standards.
  1. Monitor compliance with regulatory requirements for quality improvement and risk management opportunities and respond as needed.
  2. Ensure that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies.

**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. The security, integrity, and confidentiality of all patient information will be maintained according to Riverside Health’s policies and procedures as well as state and federal regulations. 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.
School Based Health Centers Health Visit Report Form

Addendum 1 to follow:
SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

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

SBHC Name & Address: 
SBHC Provider Number: 
Contact Name: 
Telephone: 
Fax:

MCO Name & Address: 
Contact Name: 
Telephone: 
Fax: 
Date Faxed:

Student Name: 
DOB: 
MA Number: 
SS Number:

Date of Visit: 
Type of Visit: 
☐ Acute/Urgent
☐ Follow Up
☐ Health Maintenance

ICD-9 Codes

Provider Name/Title:

CPT Codes

T: 
Hgt: 
Rapid Strep Test: -
P: 
Wgt: 
Hgb:
RR: 
BMI: 
BGL:
BP: 
U/A:
PP:
PaO2:

Drug Allergy: 
☐ NKDA

Current Medications:

Immunization review:
☐ UTD
Given today: 
Needs:

Age: 
Chief Complaint:

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

HPI:

Physical Findings:

General: 
☐ Alert/NAD
☐ Pertinent:

Head: 
☐ Normal
☐ Pertinent:

Ears: 
☐ TM's: pearly, +landmarks, +light reflex
☐ Cerumen removed curette/lavage
☐ Pertinent:

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

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

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

Neck: 
☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: 
☐ No lymphadenopathy
☐ Pertinent:

ASSESSMENT: 

PLAN: 

Rx Ordered: 
Labs Ordered: 
Radiology Services Ordered: 

PCP F/U Required: 
☐ Yes 
☐ No

Provider Signature: ________________________________

DHMH 7/2009/ch 
For MCO formulary info, find MCO website at: http://dhmh.state.md.us/mma/healthchoice/