Provider Manual

Updated: June 2026

aetna®

Aetna Better Health® of Maryland

AetnaBetterHealth.com/Maryland
1953550-MD

HealthChoice Provider Manual
Aetna Better Health of Maryland
Table of Contents

SECTION I: INTRODUCTION	
Medicaid and the HealthChoice Program	7
Overview of Aetna Better Health of Maryland	7
Member Rights and Responsibilities	9
HIPAA and Member Privacy Rights	10
Anti-Gag Provisions	12
Assignment and Reassignment of Members	12
Credentialing and Contracting	13
Provider Reimbursement	15
Self-Referral & Emergency Services	15
Maryland Continuity of Care Provisions	16
SECTION II: OUTREACH & SUPPORT SERVICES; APPOINTMENT SCHEDULING; EPSDT; and SPECIAL POPULATION	
MCO Outreach and Support Services	19
State Non-Emergency Transportation Services	19
MCO Transportation Assistance	19
State Support Services	20
Scheduling Initial Appointments	20
Early Periodic Screening Diagnosis and Treatment (EPSDT)	20
Special Populations	22
Special Needs Population – Outreach and Referral to the LHD	23
Services for Pregnant and Postpartum Women	23
Childbirth Related Provisions	25
Children with Special Health Care Needs	25
Children in State-Supervised Care	26
Individuals with HIV/AIDS	26
Individuals with Physical or Developmental Disabilities	27
Homeless Individuals	27
Referral for the Rare and Expensive Case Management (REM) Program	27
SECTION III: MEMBER BENEFITS AND SERVICES	
MCO Covered Required Benefits and Services	29
Audiology	29
Blood and Blood Products	29
Case Management Services	29
Clinical Trials Items and Services	29
Dental Services	29

Diabetes Care Services	29
Diagnostic and Laboratory Services	30
Dialysis Services	30
Disease Management	30
Doula	30
Durable Medical Equipment and Supplies	31
Early and Periodic Screening, Diagnosis, and Treatment Services	31
Family Planning Services	31
Gender Affirming Services	32
Habilitation Services	32
Home Health Services	33
Hospice Care Services	33
Inpatient Hospital Services	33
Mobile Integrated Community Health	33
Nursing Facility Services	33
Outpatient Hospital Services and Observation	33
Outpatient Rehabilitative Services	33
Over-the Counter Benefit	33
Oxygen and Related Respiratory Equipment	33
Pharmacy Services and Co-Pays	34
Plastic and Reconstructive Surgery	35
Podiatry Services	35
Pregnancy-Related Care	35
Primary Behavioral Health Services	35
Specialty Care Services	35
Telemedicine/Remote Patient Monitoring	36
Transplants	36
Vision Care Services	36
Optional Services Covered by Aetna Better Health of Maryland	36
Medicaid Benefits Covered by the State	37
Benefit Limitations (Non-Covered Services)	38
SECTION IV: PRIOR AUTHORIZATION; MEMBER COMPLAINT, GRIEVANCE & APPEAL PROCEDURES; HEALTH CHOICE COMPLAINTS; GRIEVANCES & APPEALS	
Services Requiring Preauthorization	41
Services Not Requiring Preauthorization	41
Prior Authorization Procedures	41
Inpatient Services and Concurrent Review	42
Notice of Action Requirements	42
Continuation of Benefits	43
Hospital Emergency Services	43
Concurrent Review	44
Peer-to-Peer Consultation	44
Period of Prior Authorization	44

Clinical Guidelines	45
Timeliness of Decisions & Notifications to Providers and Members	46
Decision/Notification Requirements	46
Out-of-Network Providers	48
Overview of Member Complaint, Grievance and Appeal Process	48
MCO Member Appeals Procedures	49
Request to continue benefits during the appeal	52
State Fair Hearing Rights	52
State HealthChoice Help Lines	53
SECTION V: PHARMACY MANAGEMENT	
Pharmacy Benefit Management	55
Mail Order Pharmacy	56
Prescription Copays	56
Over-the-Counter Products Injectibles and Non-Formulary Medications Requiring Prior-Authorization	56
Prior Authorization Process	57
Step Therapy and Quantity Limits	57
Maryland Opioid Prescribing Guidelines and Policies	58
SECTION VI. CLAIMS SUBMISSION, PROVIDER APPEALS, MCO QUALITY INITIATIVES AND PAY FOR-PERFORMANCE	
Facts to Know Before You Bill	62
Submitting Claims	62
Billing Inquiries	62
Checking Status of Claims	67
Claims Resubmission	67
Remittance Advice	68
Provider Appeal of Denied Claims	70
MCO Quality Initiatives	72
Provider Performance Data	73
Pay for Performance	73
SECTION VII: PROVIDER SERVICES AND RESPONSIBILITIES	
Overview of Provider Services Department	75
Availity Provider Portal	76
Provider Inquiries	78
Re-Credentialing	78
Information Changes	79
Licensure & Accreditation	79
Overview of Provider Responsibilities	79
Unique Identifier/National Provider Identifier	80
Appointment Availability Standards	80
Telephone Accessibility Standards	81

Covering Providers	83
Verifying Member Eligibility	83
Preventive or Screening Services	84
Laboratory & Radiology Results	84
Educating Members on Their Own Health Care	84
Emergency Services	84
Urgent Care Services	84
Primary Care Providers	85
PCP Contract Terminations	86
Specialty Providers	86
Specialty Providers Acting as PCPs	86
Out-of-network providers	87
Second Opinions	87
Provider Requested Member Transfer	87
Medical Records Requirements	88
Medical Records Audits	90
Access to Facilities & Records	90
Confidentiality and Accuracy of Member Records	90
Reporting Communicable Disease	90
Advanced Directives	91
Health Insurance Portability and Accountability Act of 1997 (HIPAA)	91
Cultural Competency	91
Health Literacy – Limited English Proficiency (LEP) or Reading Skills	92
SECTION VIII: QUALITY ASSURANCE MONITORING PLAN AND REPORTING FRAUD, WASTE AND ABUSE	
Quality Assurance Monitoring Plan	95
Fraud, Waste and Abuse Activities	96
Special investigations Unit (SIU)	96
Reporting Suspected Fraud and Abuse	96
Relevant Laws	98

ATTACHMENTS:	
Attachment 1: Rare and Expensive Case Management Program	102
Attachment 2: School Based Health Center Health Visit Report (MDH 2015)	110
Attachment 3: Local Health ACCU and NEMT Transportation – contact list	111
Attachment 4: Local Health Service Request Form (MDH 4682) – fillable form	112
Attachment 5: Maryland Prenatal Risk Assessment Form (MDH 4850)	114
Attachment 6: Client's Local Health Department Addresses	117
Attachment 7: Definitions	119
Attachment 8: Edifecs CRA	120
Attachment 9: Provider Manual Helpful Information	122

SECTION I
INTRODUCTION

THE MARYLAND HEALTHCHOICE PROGRAM

Medicaid and the Maryland HealthChoice Program

HealthChoice is the name of Maryland's Medicaid managed care program. There are approximately 1.5 million Marylanders enrolled in Medicaid and the Maryland Children's Health Program. With a few exceptions, Medicaid beneficiaries under age 65 must enroll in HealthChoice. Individuals that do not select a managed care organization (MCO) will be auto-assigned to an MCO with available capacity that accepts new enrollees in the county where the beneficiary lives. Individuals may apply for Medicaid, renew their eligibility and select their MCO on-line at **www.marylandhealthconnection.gov** or by calling **1-855-642-8572 (TTY: 1-855-642-8572**). Members are encouraged to select an MCO that has their primary care provider (PCP) in "Network" as participating provider. If they do not have a PCP they can choose one at the time of enrollment. MCO members who are initially auto-assigned can change MCOs within the first 90 days of enrollment. Members also have the right to change MCOs once every 12 months. The HealthChoice Program's goal is to provide patient-focused, accessible, cost-effective, high quality health care to all Medicaid Beneficiaries**.** The state assesses the quality of services provided by MCOs through various processes and data reports. To learn more about the state's quality initiatives and oversight of the HealthChoice Program go to: **https://health.maryland.gov/mmcp/healthchoice/Pages/Home.aspx**

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

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

Overview of Aetna Better Health of Maryland

Aetna Better Health of Maryland is proud to be one of the health plans chosen by the Maryland Department of Health (MDH) to serve individuals enrolled in the Maryland Health Choice Medicaid Managed Care Program ("Health Choice"), and we are available to serve Medicaid enrolled individuals in all 23 Maryland counties and Baltimore City. These counties include:

1.	Allegany	13.	Harford
2.	Anne Arundel	14.	Howard
3.	Baltimore	15.	Kent
4.	Baltimore City	16.	Montgomery
5.	Calvert	17.	Prince George's
6.	Caroline	18.	Queen Anne's
7.	Carroll	19.	St. Mary's
8.	Cecil	20.	Somerset
9.	Charles	21.	Talbot
10.	Dorchester	22.	Washington
11.	Frederick	23.	Wicomico
12.	Garrett	24.	Worcester

Aetna Better Health of Maryland uses its expertise serving Medicaid populations nationally to coordinate care for members in Maryland, and to help our participating network providers complete administrative tasks with ease. We partner and work closely with our network providers to deliver innovative health care solutions for our members. Our mission is to improve access to quality care for all members enrolled in our health plan and, to give back resources to the community to help combat social determinants of health that we serve as barriers to care for some members.

Aetna Better Health of Maryland is committed to providing a complete and comprehensive benefit package for our members that is equivalent to the benefits that are available to Maryland Medicaid participants through the Medicaid fee-for-service delivery system. Carve-out services (which are not subject to capitation and are not Aetna Better Health of Maryland's responsibility) may be accessed through the Medicaid fee-for-service system. The PCP serves as the entry point for access to health care services. The PCP is responsible for providing members with medically necessary covered services, or for referring a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member.

A member has the right to access certain services without prior referral or authorization by a PCP. This applies to specified self-referred services and emergency services. We are responsible for reimbursing out-of-plan providers who have provided these services to our members. (*See Self-Referred Services Section I*.) Only benefits and services that are medically necessary are covered. Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program.

Aetna Better Health of Maryland has pharmacy copays of $3 for non- formulary brand name drugs, $1 for formulary brand name drugs, $1 for generic formulary/non-formulary drugs, and $1 for antiretroviral medications used for prevention or treatment of HIV/AIDS. Aetna Better Health of Maryland does not charge copays for children under age 21, pregnant women, individuals in hospice, American Indian tribe members, emergency 72-hour prescription fills, and for birth control. The state has pharmacy copays for drugs covered by the state, such as behavioral health drugs.

HealthChoice Eligibility

All individuals qualifying for Maryland Medicaid or MCHP must enroll in the HealthChoice Program, except for the following categories:

- Individuals who receive Medicare;
- Individuals ages 64½ or older;
- Individuals determined eligible for Medicaid for 6 months or less spend down;
- Medicaid participants who have been or are expected to be continuously institutionalized for; more than 90 successive days in a long-term care facility or in an institution for mental disease (IMD);
- Individuals institutionalized in an intermediate care facility for persons with intellectual disabilities (ICF MR);
- Participants enrolled in the Model Waiver for Children;
- Participants who receive limited coverage, such as women who receive family planning; services through the Family Planning Waiver, 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 child who is in an out-of-state placement.

Medicaid-eligible individuals who are not eligible for HealthChoice will continue to receive services in the Medicaid fee-for service system. Members must complete an updated eligibility application every year in order to retain their coverage through the HealthChoice Program. Most members can now reapply online at **www.marylandhealthconnection.gov** or by calling **1-855-642-8572 (TYY: 1-855-642-8573).**

Members can choose their primary care provider (PCP) and can change PCPs at any time. If you are a PCP and we terminate your contract under certain circumstances the member assigned to you may elect to change to another MCO in which you participate within 90 days of the contract termination. Call the HealthChoice Provider Help Line at **1-800-766-8692** if you have questions.

It is important to remember that providers are prohibited from steering members to a specific MCO. You are only allowed to provide information on which MCOs you participate within if a current or potential member seeks your advice about selecting an MCO. Also:

- Providers must verify through the Eligibility Verification System (EVS) that participants are assigned to Aetna Better Health of Maryland before rendering services.
- Under state and federal regulations, providers are prohibited from balance billing a Medicaid beneficiary – including those individuals in the HealthChoice Program; and
- Providers may not bill a member, Medicaid or the MCO for missed appointments.

Member Rights and Responsibilities

Member rights

As HealthChoice members served by Aetna Better Health of Maryland, members have the right to:

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

- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Make recommendations regarding the organization's member rights and responsibilities policy.

Member responsibilities

As HealthChoice members served by Aetna Better Health of Maryland, members have the responsibility to:

- Inform their provider and MCO if they have any other health insurance coverage.
- Treat HealthChoice staff, MCO staff, and healthcare providers and staff, with respect and dignity.
- Be on time for appointments and notify providers as soon as possible if they need to cancel an appointment.
- Show their membership card when they check in for every appointment. Never allow anyone else to use their Medicaid or MCO card. Report lost or stolen member ID cards to the MCO.
- Call their MCO if they have a problem or a complaint.
- Work with their Primary Care Provider (PCP) to create and follow a plan of care that you and your PCP agree on.
- Ask questions about their care and let their provider know if there is something they do not understand.
- To understand your health problems and to work with your provider to create mutually agreed upon treatment goals that you will follow.
- Update the state if there has been a change in their status.
- Provide the MCO and their providers with accurate health information in order to provide proper care.
- Use the emergency department for emergencies only.
- Tell their PCP as soon as possible after they receive emergency care.
- Inform their caregivers about any changes to their Advance Directive.

HIPAA and Member Rights

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

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train all staff on HIPAA
- Consider the patient sign-in sheet
- Keep patient records, papers and computer monitors out of view
- Have an electronic shredder or locked shred bins available.

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
  - The individual's past, present or future physical or mental health, or condition.
  - The provision of health care to the individual.
  - The past, present, or future payment for the provision of health care to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
  - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
- Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health of Maryland.
- Release of data to third parties requires advance written approval from the department, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

Additional privacy requirements are located throughout this manual. Please review the "Medical Records" section for additional details surrounding safeguarding patient medical records.

For additional training or Q&A, please visit the following site at
http://aspe.hhs.gov/admnsimp/final/pvcguide1.htm

Member Privacy Rights
Aetna Better Health of Maryland's privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, Maryland, and local laws and regulations, and applicable contractual requirements. Our privacy policy conforms with 45 C.F.R. (Code of Federal Regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526, and 528).

Our policy also assists Aetna Better Health of Maryland personnel and providers in meeting the privacy requirements of HIPAA when members or authorized representatives exercise privacy rights through privacy request, including:

- Making information available to members or their representatives about Aetna Better Health of Maryland's practices regarding their PHI.
- Maintaining a process for members to request access to, changes to, or restrictions on disclosure of their PHI.
- Providing consistent review, disposition, and response to privacy requests within required time standards.
- Documenting requests and actions taken.

Member privacy requests
Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint
- Receive a copy of all or part of the designated record set
- Amend records containing PHI
- Receive an accounting of health plan disclosures of PHI
- Restrict the use and disclosure of PHI
- Receive confidential communications
- Receive a Notice of Privacy Practices

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that he or she is authorized to make the request on behalf of the member or the deceased member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to Aetna Better Health of Maryland in writing.

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

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

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

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

- If they move to another county where **Aetna Better Health of Maryland does** not offer care;
- If they become homeless and find that there is another MCO closer to where they live or have shelter which would make getting to appointments easier;

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

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

PCPs can pull a report of the members that have been paneled to them via the online provider portal. PCPs should contact Member Services if there are questions concerning their member panel. PCPs should confirm eligibility at the time of service, as information changes daily and should not be used to determine member eligibility. MCO members may change PCPs at any time. Members can call Member Services Monday-Friday 8 AM-5 PM time at **1-866-827-2710** to change their PCP.

Procedure for closing a PCP Panel
A PCP who no longer wishes to accept new Aetna Better Health of Maryland members may submit a written notification to Network Relations to close his or her panel. In this situation, any new member who is not an established patient of that PCP cannot select that PCP's office with an approved closed panel.

A PCP may reopen a "closed" panel by submitting a written notification to Provider Relations. This change will be made on the first of the month following submission of the request, no less than thirty days from receipt of the written request. Additional time may be necessary to update printed marketing materials.

When an Aetna Better Health of Maryland member chooses a PCP who has a "closed" panel, Member Services will notify the subscriber of the provider's panel status. If the provider chooses to make an exception to accept the member, they should contact Member Services for assistance in facilitating an override to assign members to their practice on a case-by-case basis.

Credentialing and Contracting with Aetna Better Health of Maryland
Aetna Better Health of Maryland uses current NCQA standards and state guidelines for the review, credentialing and recredentialing of providers, and uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America's leading health plans collaborating through CAQH. The Universal Credentialing DataSource is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process. Paper applications can be obtained by contacting Provider Services at **1-866-827-2710**.

The Universal Credentialing DataSource Program allows providers to use a standard application and a common database to submit one application, to one source, and update it on a periodical basis to meet the needs of all of the health plans and hospitals participating in the CAQH effort. Health plans and hospitals designated by the providers obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the provider for the same standard information. Providers update their information on a quarterly basis to verify data is maintained in a constant state of readiness. The Council for Affordable Quality Healthcare (CAQH) gathers and stores detailed data from more than 600,000 providers nationwide. All new providers (with the exception of hospital-based providers), including providers joining an existing participating practice with Aetna Better Health of Maryland, must complete the credentialing process and be approved by the Credentialing Committee.

Providers are recredentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and DEA certificates are also required. Please note that providers may NOT treat members until they are credentialed.

Providers that will handle credentialing themselves must enter into a Delegated Agreement with Aetna Better Health of Maryland and submit to a credentialing audit before a provider agreement can be executed. Once the provider meets the requirements of the audit, the group must comply with annual audits to ensure continued compliance with NCQA, state and regulatory requirements. In addition, delegated providers are required to submit credentialing reports to Aetna Better Health of Maryland on at minimum, a quarterly basis.

electronic Provider Revalidation and Enrollment Portal (ePREP)
Federal rules require that MCO providers enroll with the MCO's state Medicaid agency 42 CFR Part 438, Subpart H. To render Medicaid reimbursable services, providers must enroll with the Maryland Medical Assistance Program (Medicaid), **even if your practice will be providing services only to HealthChoice participants.** Enrolling with Medicaid does not mean that you must provide services to Fee-for-Service (FFS) participants.

The Maryland Department of Health requires MCOs verify ePrep enrollment at the time of initial and recredentialing. Credentialing will be impacted for providers that are not enrolled in ePrep.

The Maryland Department of Health **Provider Revalidation and Enrollment** is a one-stop shop for provider enrollment and demographic changes.

Contact Information:
https://mmcp.health.maryland.gov/Pages/ePREP.aspx
1-844-4MD-PROV (1-844-463-7768)

Provider enrollment
Aetna Better Health of Maryland handles provider enrollment using a 7-step process.

- Step 1: Roster submission with contracting documents; our template is forwarded to providers by the Aetna Better Health network manager that is handling their contract.
- Step 2: Contract is signed, credentialing application is submitted, and roster information is entered into our system. If there is missing information, Aetna Better Health will follow up with the provider.
- Step 3: Credentialing notice is sent to provider. This notice advises the provider that Aetna Better Health has all information to begin the process. Providers from roster and set up in system to align with billing tax identification number (TIN); provider NPIs and service locations.

- Step 4: Provider goes through the credentialing process, which can take up to 120 days. If a provider has been credentialed by Aetna's commercial line of business, we do not require separate credentialing with Aetna Better Health of Maryland. This allows our Credentialing department to expedite the credentialing process and so you can provide quality medical care, even sooner, to our members.
- Step 5: Provider completes credentialing process.
- Step 6: Credentialing complete letter and welcome packet is sent to provider.
- Step 7: Provider is enrolled in Aetna Better Health of Maryland systems and provider directory.

New providers can be added to your practice at any time; however, it is important to remember that each new provider must complete credentialing. Please contact us at **ABHMDCredentialing@aetna.com** if there are questions.

It is critical that Aetna Better Health of Maryland maintains accurate provider information. We need your help by notifying our Provider Enrollment department of all changes to your clinical staff, including roster additions and termination. **We encourage you to submit roster updates to our Provider Enrollment department monthly.** This practice ensures that we have your most up to date information for our provider director and Documents section of our secure web portal. The completed roster template should be e-mailed to **MarylandProviderRelationsDepartment@aetna.com**.

Provider Reimbursement

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

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

Self-Referral and Emergency Services

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

The state allows members to self-refer for the services listed below. Aetna Better Health of Maryland will pay out of plan providers the state's Medicaid rate for the following services:

- Emergency services provided in a hospital emergency facility;
- Family planning services excluding sterilizations;
- Maryland school-based health center services. School-based health centers are required to send a medical encounter form to the child's MCO. We will forward this form to the child's PCP who will be responsible for filing the form in the child's medical record. See Attachment 2 ~~3~~ for a sample School Based Health Center Report Form;
- Pregnancy-related services when a member has begun receiving services from an out-of-plan provider prior to enrolling in an MCO;

- Initial medical examination for children in state custody (Identified by Modifier 32 on the claim);
- Annual Diagnostic and Evaluation services for members with HIV/AIDS;
- Renal dialysis provided at a Medicare-certified facility;
- The initial examination of a newborn by an on-call hospital physician when we do not provide for the service prior to the baby's discharge; and
- Services performed at a birthing center;
- Children with special health care needs may self-refer to providers outside of Aetna Better Health of Maryland network under certain conditions. *See Section II for additional information*.

If a provider renders any of the services listed above, the provider must follow our billing and preauthorization procedures. Reimbursements will be paid at the contracted rate. Aetna Better Health of Maryland maintains an auto-pay list of emergent diagnosis which is available on our website at **www.aetnabetterhealth.com/maryland/providers/forms.html** or via request to our provider relations department. Claims for emergency services with diagnosis codes on the auto-pay list will be paid in full without further documentation. An initial screening/assessment fee, revenue code 0451, will be paid for any (Emergency Department) ER visit not included on the auto-pay list. Additional payment for (Emergency Department) ER visits not included on the auto-pay list requires supporting clinical notes. Revenue 450 can be billed alone in lieu of 451 and 452 of the visit; 452 cannot be billed alone. In accordance Health Services Cost Review Commission (HSCRC), federal EMTALA and Maryland Department of Health requirements, Aetna Better Health of Maryland pays the EMTALA Medical Screening, revenue code 451, (Emergency Department) ER Beyond EMTALA Screening, revenue code 452 and ancillary charges. Aetna Better Health of Maryland maintains an auto-pay list of emergent diagnosis, which is available on our website or the Availity Portal. Claims for emergency services with diagnosis codes

Aetna Better Health of Maryland reserves the right to audit claims for consistency between clinical documentation and information presented on the bill.

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

- Is new to the HealthChoice Program;
- Switched from another company's health benefit plan; or
- Switched to Aetna Better Health of Maryland from another MCO.

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

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

Preauthorization for health care services
If the previous MCO or company preauthorized services, we will honor the approval if the member calls **1-866-827-2710**. Under Maryland law, insurers must provide a copy of the preauthorization within 10 days of the member's request. There is a time limit for how long we must honor this preauthorization. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health practitioner after the baby is born.

Right to use non-participating providers

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

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

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

If the member has any questions, they should call Aetna Better Health of Maryland Member Services at **1-866-827-2710** or the state's HealthChoice Help Line at **1-800-284-4510**.

SECTION II

OUTREACH & SUPPORT SERVICES
APPOINTMENT SCHEDULING
Early Periodic Screening Diagnosis and Treatment (EPSDT)
SPECIAL POPULATIONS

MCO Member Outreach and Support Services
Aetna Better Health of Maryland's outreach and enrollment staff are trained to work with members with special needs and to be knowledgeable about their care needs and concerns. Our staff uses interpreters when necessary to communicate with members who prefer not to or are unable to communicate in English and use the Maryland Relay system and American Sign Language interpreters, if necessary.

Aetna Better Health of Maryland's requires that our contracted providers must confirm the use of the most current diagnosis and treatment protocols and standards established by the Maryland Department of Health and medical community. During initial provider orientations, we will highlight and reinforce the importance of using the most current diagnosis and treatment protocols.

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized health care services, the member may receive care from a contracted specialist, or a contracted specialty care center with expertise in treating the life-threatening disease or specialized condition. The specialist or specialty care center will be responsible for providing and coordinating the member's primary and specialty care. The specialist or specialty care center, acting as both primary and specialty care provider, will be permitted to treat the member without a referral from the member's Primary Care Provider (PCP), and may authorize referrals, procedures, tests and other medical services. If approval is obtained to receive services from a non-network provider, the care will be provided at no cost to the member. If our network does not have a provider or center with the expertise the member requires, we will authorize care out of network.

After-hours protocol for members with special needs is addressed during initial provider training. Providers must be aware that non-urgent conditions for an otherwise healthy member may indicate an urgent care need for a member with special needs. We expect our contracted providers to have systems for members with special needs to reach a provider outside of regular office hours. Aetna Better Health of Maryland's Nurse Line (**1-866-827-2710**) is available 24 hours a day 7 days a week for members with an urgent situation or crisis.

State Non-Emergency Medical Transportation (NEMT) Assistance
If a member needs transportation assistance, contact the local health department (LHD) to assist the member in accessing non-emergency medical transportation services (NEMT). Aetna Better Health of Maryland will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD. **See Attachment 3 for NEMT contact information**.

MCO Transportation Assistance
Under certain circumstances, Aetna Better Health of Maryland may provide limited transportation assistance when members do not qualify for NEMT through the LHD. Aetna Better Health of Maryland has contracted with Maryland based transportation vendors to meet the needs of its members. Please contact the Aetna Better Health of Maryland Member Services Department at **1-866-827-2710** for assistance.

Nurse Information Line
After a member is treated for an emergency medical condition, they may need additional services to make sure the emergency medical conditions do not return. If unable to reach their PCP they may also contact the Nurse Information Line 24 hours a day for guidance at **1-866-827-2710 (TTY: 711**) and select the option for the *Nurse*.

State Support Services
The state provides grants to local health departments (LHDs) to operate Administrative Care Coordination/Ombudsman Units (ACCU) to assist with outreach to certain state designated special populations and non-complaint HealthChoice members. MCOs and providers are encouraged to develop collaborative relationships with the local ACCU. **See Attachment 3 for ACCU contact information**. If you have questions, call the Division of Outreach and Care Coordination at **410-767-6750** which oversees the ACCUs or the HealthChoice Provider Help Line at **1-800-766-8692**.

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

- You determine that no immediate initial appointment is necessary because the member already has an established relationship with you.
- For children under 21, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) periodicity schedule requires a visit in a shorter timeframe. For example, new members up to two years of age must have a well-child visit within 30 days of enrollment unless the child already has an established relationship with a provider and is not due for a well-child visit.
- For pregnant and post-partum members who have not started to receive care, the initial health visit must be scheduled, and the women seen within 10 days of a request.
- As part of the MCO enrollment process, the state asks the member to complete a Health Services Needs Information (HSNI) form. This information is then transmitted to the MCO. A member who has an identified need must be seen for their initial health visit within 15 days of Aetna Better Health of Maryland receipt of the HSNI.
- During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age-appropriate physical exam.
- In addition, at the initial health visit, initial prenatal visit, or when a member's physical status, behavior, or laboratory findings indicate possible substance use disorder, you must refer the member to the Behavioral Health System at **1-800-888-1965**.

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

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

- Notify members of their due dates for wellness services and immunizations**.**
- Schedule and provide preventive health services according to the state's EPSDT periodicity schedule and screening manual.
- Refer infants and children under age 5 and pregnant teens to the Supplemental Nutritional Program for Women, Infants and Children (WIC). Provide the WIC program with member information about hematocrits and nutrition status to assist in determining a member's eligibility for WIC.

- Participate in the Vaccines For Children (VFC) program. Many of the routine childhood immunizations are furnished under the VFC program. The VFC program provides free vaccines for health care providers who participate in the VFC program. We will pay for new vaccines that are not yet available through the VFC program.
- Schedule appointments at an appropriate time interval for any member who has an identified need for follow-up treatment as the result of a diagnosed condition.

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

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

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

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

EPSDT Outreach and Referral to LHD

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

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

Schedule a second appointment within 30 days of the first missed appointment. Within 10 days of the child missing the second consecutive appointment, request assistance in locating and contacting the child's parent, guardian or caretaker by calling Aetna Better Health of Maryland at **1-866-827-2710**.
You may concurrently make a written referral to the LHD ACCU by completing the Local Health Services Request form. **See Attachment 4 or visit the website:**
https://health.maryland.gov/mmcp/pages/Local-Health-Services-Request-Form.aspx. Continue to work collaboratively with Aetna Better Health of Maryland and the ACCU until the child is in care and up to date with the EPSDT periodicity schedule or receives appropriate follow-up care.

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

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

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

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

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

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

- Upon the request of the member or the PCP, a case manager trained as a nurse or a social worker will be assigned to the member. The case manager will work with the member and the PCP to plan the treatment and services needed. The case manager will not only help plan the care but will help keep track of the health care services the member receives during the year and will serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and our case managers, when required, coordinate referrals for needed specialty care. This includes specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. **PCPs should follow the referral protocols established by us for sending HealthChoice members to specialty care networks.**
- We have a Special Needs Coordinator on staff to focus on the concerns and issues of special needs populations. The Special Needs Coordinator helps members find information about their condition or suggests places in their area where they may receive community services and/or referrals. To contact the Special Needs Coordinator, call **1-866-827-2710**.
- Providers are required to treat individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 (P.L. 101-336 42 U.S.C. 12101 et. seq. and regulations promulgated under it).

Special Needs Population – Outreach and Referral to the LHD
A member of a special needs population who fails to appear for appointments or who has been non-compliant with a regimen of care must be referred to Aetna Better Health of Maryland. If the PCP or specialist finds that a member continues to miss appointments, call Aetna Better Health of Maryland at **1-866-827-2710.** We will attempt to contact the member by mail, telephone and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the LHD ACCU. You may also make a written referral to the LHD ACCU by completing the Local Health Services Request Form. (***See Attachment 4 or https://mmcp.MDH.maryland.gov/pages/Local-Health-Services-Request-Form.aspx*)**. The local ACCU staff will work collaboratively with Aetna Better Health of Maryland to contact the member and encourage them to keep appointments and provide guidance on how to effectively use their Medicaid/HealthChoice benefits.

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

Aetna Better Health of Maryland and our providers are responsible for providing pregnancy-related services, which include:

- Comprehensive prenatal, perinatal, and postpartum care (including high-risk specialty care);
- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment form MDH 4850. (For updated form visit: **https://health.maryland.gov/mmcp/Documents/Maryland Prenatal Risk Assesment – Revised 10.4.22.pdf**
- An individualized plan of care based upon the risk assessment and which is modified during the course of care as needed;
- Appropriate levels of inpatient care, including emergency transfer of pregnant members and newborns to tertiary care centers;
- Case management services;
- Prenatal and postpartum counseling and education including basic nutrition education;
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant members .
- Doula support for prenatal visits, attendance at labor and delivery, and postpartum visits;
- Prenatal, postpartum, and infant home visits from pregnancy and childbirth up to two or three years of the child's age.

The state provides these additional services for pregnant members:

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

Encourage all pregnant members to call the state's Help Line for Pregnant Woman at **1-800-456-8900**. This is especially important for members who are newly eligible or not yet enrolled in Medicaid. If the member is already enrolled in HealthChoice call us and also instruct them to call Aetna Better Health of Maryland at **1-866-827-2710.**

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

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

The prenatal care provider, PCP and Aetna Better Health of Maryland are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcome. Examples of an appropriate referral include the Women Infants and Children special supplemental nutritional program (WIC). Prenatal care providers are also required to:

- Provide the initial health visit within 10 days of the request.
- Complete the Maryland Prenatal Risk Assessment form-MDH 4850 (See Attachment 5) and submit it to the Local Health Department within 10 days of the initial visit. Aetna Better Health of Maryland will pay for the initial prenatal risk assessment in the first trimester, within 42 days of plan enrollment and with notification of pregnancy to the health plan use CPT code H1000.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- At each visit, provide health education relevant to the member's stage of pregnancy. Aetna Better Health of Maryland will pay for this – use CPT code H1003 for an "Enriched Maternity Services"- You may only bill for one unit of "Enriched Maternity Services" per visit. Refer pregnant and postpartum members the WIC Program.
- Reschedule appointments within 10 days if a member misses a prenatal appointment.
- Call Aetna Better Health of Maryland if a prenatal appointment is not kept within 30 days of the first missed appointment.
- If under the age 21, refer the member to their PCP to have their EPSDT screening services provided.
- Refer pregnant members to the Maryland Healthy Smiles Dental Program. Members can contact Healthy Smiles at **1-855-934-9812**; TDD: **1-855-934-9816**; Web portal: **http://member.mdhealthysmiles.com/** if you have questions about dental benefits.
- Refer pregnant and postpartum members who may be in need of diagnosis and treatment for a mental health or substance use disorder to the Behavioral Health System; if indicated they are required to arrange for substance abuse treatment within 24 hours.
- Educate pregnant members on doula services or refer eligible members for home visits if medically necessary and appropriate.
- Record the member's choice of pediatric provider in the medical record prior to their eighth month of pregnancy. We can assist in choosing a PCP for the newborn. Advise the member that she should be prepared to name the newborn at birth. This is required for the hospital to complete the "Hospital Report of Newborns", MDH 1184. (The hospital must complete this form so Medicaid can issue the newborns ID number.) The newborn will be enrolled in the postpartum member's MCO.

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

- A member's length of hospital stay after childbirth is determined in accordance with the ACOG and AAP Guidelines for perinatal care; unless the 48-hour (uncomplicated vaginal delivery) / 96-hour (uncomplicated cesarean section) length of stay guaranteed by state law is longer than that required under the Guidelines.
- If a member must remain in the hospital after childbirth for medical reasons, and the member requests that their newborn remain in the hospital while they are hospitalized, additional hospitalization of up to 4 days is covered for the newborn and must be provided.
- If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by state law, a home visit must be provided. When a member opts for early discharge from the hospital following childbirth, (before 48 hours for vaginal delivery or before 96 hours for C-section) one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.

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

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

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

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

We are required to schedule the newborn for a follow-up visit within 2 weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit. Breast pumps are covered for all breast-feeding members. Call us at **1-866-827-2710** for more information**.**

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

New member: A child who, at the time of initial enrollment, was receiving these services as part of a current plan of care may continue to receive these specialty services provided the preexisting 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 Aetna Better Health of Maryland and we approve the services as medically necessary.

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

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

For children with special health care needs Aetna Better Health of Maryland will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions, social services, or both, a multi-disciplinary team must be used to review and develop the plan of care for children with special health care needs.
- Refer special needs children to specialists as needed. This includes specialty referrals for children who have been found to be functioning one third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
- Allow children with special health care needs to access out-of-network specialty providers under certain circumstances. We log any complaints made to the state or to Aetna Better Health of Maryland about a child who is denied a service by us. We will inform the state about all denials of service to children. All denial letters sent to children or their representative will state that members can appeal by calling the state's HealthChoice Help Line at **1-800-284-4510**.
- Work closely with the schools that provide education and family services programs to children with special needs.

Children in State-Supervised Care

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

Aetna Better Health of Maryland will provide case management services for any member who is diagnosed with HIV. These services will be provided with the member's consent and will facilitate timely and coordinated access to appropriate levels of care and support continuity of care across the continuum of qualified service providers. If a member initially refuses HIV case management services, they may request services at a later time. The member's case manager will serve as the member's advocate to resolve differences between the member and providers pertaining to the course or content of therapeutic interventions.

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

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

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

Rare and Expensive Case Management (REM) Program
The Rare and Expensive Case Management (REM) Program is an alternative to managed care for children and adults with certain diagnosis who would otherwise be required to enroll in HealthChoice. If the member is determined eligible for REM, they can choose to stay in Aetna Better Health of Maryland or they may receive services through the traditional Medicaid fee-for-service program. They cannot be in both an MCO and REM. See Attachment 1 for the list of qualifying diagnosis and a full explanation of the referral process.

SECTION III

HEALTHCHOICE BENEFITS AND SERVICES

MCO Benefits and Services Overview
Aetna Better Heath of Maryland must provide comprehensive benefits equivalent to the benefits that are available to Maryland Medicaid participants through the Medicaid fee-for-service system. Only benefits and services that are medically necessary are covered.

Audiology Services
Audiology services will be covered by Aetna Better Health of Maryland for both adults and children including cochlear implants based on medical necessity. For individuals under age 21, bilateral hearing amplification devices are covered by the MCO. For adults 21 and older, unilateral hearing amplification devices are covered by the MCO. Bilateral hearing amplification devices are only covered for adults 21 and older when the individual has a documented history of using bilateral hearing aids before age 21. Services may not be billed to the program for any rendered by mail, telephone, or otherwise not one-tone, in person.

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

Case Management Services
We cover case management services for members who need such services including, but not limited to**,** members of state designated special needs populations, which consist of the following non-mutually exclusive populations (See Section II):

- Pregnant and postpartum women
- Children with special health care needs
- Children in state supervised care
- Individuals with HIV/AIDS
- Individuals with a physical or developmental disability
- Individuals who are homeless
- Individuals with behavioral health needs
- Individuals with asthma

If warranted, a case manager will be assigned to a member when the results of the initial health screen are received by the MCO or when requested by the state. A case manager may conduct home visits as necessary as part of Aetna Better Health of Maryland case management program.

Clinical Trial Items and Services
We cover certain routine costs that would otherwise be a cost to the member.

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

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

- Diabetes nutrition counseling
- Diabetes outpatient education

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

Diabetes Prevention Program

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

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

Diagnostic and Laboratory Services

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

Dialysis services

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

Disease management

We offer disease management for members with chronic conditions including:

- Asthma (adult and pediatric modules)
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Depression
- Diabetes
- Heart failure (HF)

Doula

Doula support is available for prenatal visits, attendance at labor and delivery, and postpartum visits. You also have access to home visiting services. Home visiting services provide support to pregnant women during pregnancy and childbirth, as well as support for parents and children during the postpartum period and up to two or three years of age. Home visiting services include prenatal home visits, and infant home visits. Group-based support centering around pregnancy is also available to provide education and support with members that are due around the same time as you.

Durable Medical Services (DMS) and Durable Medical Equipment (DME)

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

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

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

We must cover EPSDT services listed below for members under 21 years of age:

- Well-child services provided in accordance with the EPSDT/Healthy Kids periodicity schedule by an EPSDT-certified provider, including:
  - Periodic comprehensive physical examinations;
  - Comprehensive health and developmental history, including an evaluation of both physical and mental health development;
  - Immunizations;
  - Laboratory tests including blood level assessments;
  - Vision, hearing, and dental screening; and
  - Health education.

- The state must also provide or assure the MCO provides expanded EPSDT services and partial or inter-periodic well-child services necessary to prevent, treat, or ameliorate physical, mental, or developmental problems or conditions. Services must be sufficient in amount, duration, and scope to treat the identified condition, and are covered subject to limitations only based on medical necessity. These include such services as:
  - Chiropractic services;
  - Nutrition counseling;
  - Private duty nursing services;
  - Durable medical equipment including assistive devices; and
  - Behavioral health services

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

Family Planning Services

We will cover comprehensive family planning services such as:

- Office visits for family planning services;
- Laboratory tests including pap smears;
- All FDA approved contraceptive devices; methods and supplies;

- Immediate postpartum insertion of IUDs
- Oral contraceptives (12-month supply can be dispensed for refills);
- Emergency contraceptives and condoms without a prescription;
- Voluntary sterilization procedures (Sterilization procedures are not self-referred; member must be 21 years of age and must use in-network provider or have authorization for out of network care.)

Fertility Preservation Services

We cover medically necessary fertility preservation services for Iatrogenic Infertility. Iatrogenic fertility includes impairment of fertility by surgery, radiation, chemotherapy, gender-affirming treatments, or other medical treatment or intervention affecting reproductive organs or processes. The following fertility preservation services will be covered:

- Fertility preservation consultation;
- Fertility preservation procedures including applicable laboratory assessments, medications, and medically necessary treatments;
- For the purposes of oocyte retrieval only, ovulation induction, monitoring, oocyte retrieval;
- Oocyte cryopreservation and evaluation;
- Ovarian tissue cryopreservation and evaluation;
- Sperm extraction, cryopreservation, and evaluation
- Transposition of the ovary(s); and
- Gonadal Suppression with GNRH Analogs;
  - GnRH agonist may be offered to breast cancer patients to reduce the risk of premature ovarian insufficiency; and
  - Not to be used in place of other fertility preservation alternatives.

The following fertility preservation services limitations (non-covered) to include:

- Donor sperm;
- Donor oocytes;
- Fertility procedures such as:
  - Intrauterine insemination procedures; or
  - In vitro fertilization procedures;
- Storage and thawing of testicular tissue;
- Prepubertal testicular tissue cryopreservation when considered investigational;
- Sperm and oocyte banking and storage; and
- Thawing of cryopreserved sperm or oocytes

Gender Affirming Services

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

Habilitation Services

We cover habilitation services when medically necessary for certain adults who are eligible for Medicaid under the ACA. These services include: physical therapy, occupational therapy and speech therapy. Call **1-866-827-2710** if you have questions about which adults are eligible.

Home Health Services

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

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

Hospice Care Services

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

Inpatient Hospital Services

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

Mobile Integrated Community Health

We cover Mobile Integrated Health services provided by approved EMS agencies for eligible adults.

Nursing Facility Services

For members that were enrolled in Aetna Better Health of Maryland prior to admission to a Long-Term Care (LTC)/Nursing Facility (NF) and who meet the state's level of care (LOC) criteria, we are responsible for up to 90 days of the stay subject to specific rules.

Outpatient Hospital Services

We cover medically necessary outpatient hospital services. As required by the state we limit observation stays to 24 hours.

Outpatient and Rehabilitative Services

We cover outpatient rehabilitative services including but not limited to medically necessary physical therapy for adult members. For members under 21, rehabilitative services are covered by Aetna Better Health of Maryland when the service is part of a home health visit, chiropractic or inpatient hospital stay. All other rehabilitative services for members under 21 must be billed to the state's Medicaid fee-for-service program.

Oxygen and Related Respiratory Equipment

We cover oxygen and related respiratory equipment.

Pharmacy Services and Copays

We are responsible for most pharmacy services. We will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program.

We cover medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider. Most behavioral health drugs are on the state's formulary and are the responsibility of the state.

Aetna Better Heath of Maryland has pharmacy copays of $3 for non-formulary brand name drugs, $1 for formulary brand name drugs, $1 for generic formulary and non- formulary drugs, and $1 for antiretroviral medications used for prevention or treatment of HIV/AIDS. Aetna Better Health of Maryland does not charge copays for children under age 21, pregnant women, individuals in hospice, American Indian tribe members, for birth control, and emergency 72-hour prescription fills.

This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high risk and special needs populations and vaccines prescribed to protect individuals against vaccine-preventable diseases. If a generic equivalent drug is not available, new brand name drug rated as P (priority) by the FDA will be added to the formulary.

Coverage may be subject to preauthorization to ensure medical necessity for specific therapies. For formulary drugs requiring preauthorization, a decision will be provided within 24 hours of request. When a prescriber believes that a non-formulary drug is medically indicated, we have procedures in place for non-formulary requests. The state expects a non-formulary drug to be approved if documentation is provided indicating that the formulary alternative is not medically appropriate. Requests for non-formulary drugs will not be automatically denied or delayed with repeated requests for additional information.

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

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

Most behavioral health drugs on the state's formulary are the responsibility of the state.

Neither the state nor the MCO will cover the following:

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

Plastic and Restorative Surgery

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

Podiatry Services

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

Pregnancy-Related Care

See SECTION II: Services for Pregnant and Postpartum Members.

Primary Behavioral Health Services

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

Specialty Care Services

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

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

A member's PCP is responsible for making the determination, based on our referral requirements, of whether or not a specialty care referral is medically necessary. PCPs must follow our special referral protocol for children with special healthcare needs who suffer from a moderate to severe chronic health condition which:

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

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

Telemedicine and Remote Patient Monitoring

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

Transplants

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

Vision care services

We cover medically necessary vision care services. We cover one eye examination every two years, for members age 21 and older and $200 towards eyewear (glasses or contact lenses).; and for members under the age 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.

Optional Services Covered by Aetna Better Health of Maryland

In addition to those services previously noted, Aetna Better Health of Maryland currently provides the following optional services to our members. These services are not taken into account when setting our capitation rate. Aetna Better Health of Maryland's **optional** services may change each calendar year. We may not discontinue or reduce these services without providing advance notification to the state.

BENEFIT	WHAT IT IS	WHO CAN GET IT
Adult vision	Members are eligible for an annual exam and $200 towards the cost of prescription glasses or contact lenses.	Members >21 years
Disposable diaper program	Members newborn to 24 months can get a monthly supply of disposable diapers. Members must attest that the child is up to date on their well-child visits.	Members newborn to 24 months
Android Smartphone	Free monthly lifeline service with free minutes, data and unlimited text messaging for members 18 years and older.	Members >18 years
Feminine hygiene	Female members, ages 10 to 55 years, can request a mail-ordered 3 month supply of pads or tampons.	Female members ages 10 to 55 years
Maternity Matters Pregnancy Program	Pregnant members are encouraged to make early and frequent prenatal and postpartum visits. Program includes: Redeemable reward of $100 for first prenatal visit in the first trimester, within 42 days of plan enrollment and with notification of pregnancy to the health plan. Members earn a $10 gift card for dental visit and additional rewards (up to $75) for going to prenatal and postpartum appointments.	Pregnant and postpartum members
Additional transportation services	Limited rides for required medical appointments only. Limit 12 round trips per year maximum.	All members

After school engagement	Members ages 5 to 18 can get up to $60 gift card per year for activities at participating YMCA, Boys and Girls Clubs, Boy Scout or Girl Scouts	Members ages 5 to 18
Carpet cleaning	Members with asthma and COPD may receive one $150 gift card towards the cost of carpet cleaning services. Limit one $150 gift card per household.	All members
School uniforms	Members enrolled in grade 1 to grade 5, who have completed health screenings and wellness visits will qualify for a $100 gift card towards school uniforms.	Members enrolled in grades 1 to 5
CampusED	Members can earn their GED and learn new job skills at no cost. Access to prep courses, assistance with scheduling their exam, and an exam fee voucher. Career services support, resume assistance, opportunities to earn digital badges, and access to local network of recruiting employers.	Members age 16+
Swimming Lessons	Members receive up to $50 gift card towards the cost of swimming lessons with drowning prevention.	All members
Over the Counter Benefit	Each member can order $15 per month of certain Over the Counter (OTC) drugs and select grocery items from a catalog. Items may be ordered monthly online or by phone. The items will be mailed directly to the members home.	All members
MyActiveHealth	A health assessment tool that makes it easier to take charge of your health. Includes health surveys and records, educational videos and podcast, health lifestyle programs, and more.	All members
Ted E Bear M.D.® Kids Club	Member incentives include weight management, healthy living education and sports activity fee payments for organized local youth programs and team sports.	Members ages 2 to 18

Medicaid Benefits Covered by the State – not Covered by Aetna Better Health of Maryland

- The state covers dental services for all members who receive full Medicaid benefits for children under age 21, HealthChoice adults, former foster care youth up to age 26, and pregnant women. The Maryland Healthy Smiles Dental Program is responsible for routine preventative services, restorative service and orthodontia. Orthodontia must meet certain criteria and requires preauthorization by SKYGEN USA, the state's ASO. SKYGEN USA assigns members to a dentist and issues a dental Healthy Smiles ID card. However, the member may go to any Healthy Smiles participating dentist. If you have questions about dental benefits call **1-855-934-9812.**
- Outpatient rehabilitative services for children under age 21.
- Specialty mental health and substance use disorders covered by the Specialty Behavioral Health System.
- Intermediate Care Facilities for Individuals with Intellectual Disabilities or Persons with developmental disabilities.
- Personal care services.
- Medical day care services, for adults and children.
- Dental surgery fees for the facility and general anesthesia for members under age 21, pregnant women, and former foster care youth up to age 26.
- Abortions (covered under limited circumstances – no federal funds are used – claims are paid through the Maryland Medical Care Program). If a member was determined eligible for Medicaid based on their pregnancy, they are not eligible for abortion services.

- Emergency transportation (billed by local EMS).
- Non-emergency transportation services provided through grants to local governments;
- Services provided to members participating in the state's health home program; and
- Certain high-cost low-volume drugs.

Benefit Limitations

Aetna Better Health of Maryland does not cover these services except where noted, and the state does not cover these services.

- Services performed before the effective date of the member's enrollment in the MCO are not covered by the MCO but may be covered by Medicaid fee-for-service if the member was enrolled in Medicaid;
- Services that are not medically necessary.
- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state).
- Services that are beyond the scope of practice of the health care practitioner performing the service;
- Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when a member is participating in an authorized clinical trial.
- Cosmetic surgery to improve appearance or related services, but not including surgery and related services to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental abnormalities.
- While enrolled in an MCO, services, except for emergency services, are not covered when the member is outside the state of Maryland unless the provider is part of Aetna Better Health of Maryland's network. Services may be covered when provided by an MCO network provider who has obtained the proper referral or preauthorization if required. If a Medicaid beneficiary is not in an MCO on the date of service, Medicaid fee-for service may cover the service if it is a covered benefit and if the out of state provider is enrolled in Maryland Medicaid.
- Services provided outside the United States.
- Immunizations for travel outside the U.S.
- Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis.
- Private hospital room is not covered unless medically necessary or no other room is available.
- Autopsies.
- Private duty nursing services for adults 21 years old and older.
- Orthodontia is not covered by the MCO but may be covered by Healthy Smiles when the member is under 21 and scores at least 15 points on the Handicapping Labio-lingual Deviations Index No. 4 and the condition causes dysfunction.
- Ovulation stimulants, in vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar.
- Reversal of voluntary sterilization procedures.
- Medications for the treatment of sexual dysfunction.
- MCOs are not permitted to cover abortions. We are required to assist members in locating these services and we are responsible for related services (sonograms, lab work, but the abortion procedure, when conditions are met, must be billed to Medicaid fee-for-service)
- Non-legend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the member is under 12 years old and non-legend drugs other than insulin and enteric-coated aspirin for arthritis.
- Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational

therapy.

- Diet and exercise programs for weight loss except when medically necessary.
- Lifestyle improvements (physical fitness programs and nutrition counseling, unless specified); and MCOs do not cover non-emergency transportation services (NEMT) or emergency transportation services. We will assist members to access non-emergency transportation through the designated local agency. We will provide some transportation if necessary, to fill any gaps that may temporarily occur in our network. Aetna Better Health of Maryland offers additional transportation services. Providers should contact Member Services at **1-866-827-2710** for more information.

Section IV

PRIOR AUTHORIZATION AND MEMBER COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

Services requiring prior authorization
The list of services that require prior authorization by Aetna Better Health of Maryland are on our secure Web Portal located on our website, **AetnaBetterHealth.com/Maryland**. This list is consistent with Aetna Better Health of Maryland's policies and governing regulations. The list is updated at least annually and updated periodically as appropriate.

If unforeseen circumstances require that a surgical procedure goes beyond the scope of the initial authorization, clinical information about the medical necessity of the additional procedures/CPT codes should be reported to the health plan within two business days via fax to **1-855-661-1967**. Surgical procedures approved may include an overnight stay in observation (24 hours).

Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment. All out of network services must be authorized except Self-referred services as outlined in Section I.

Services Not Requiring Preauthorization
Members may access family planning services, except sterilization from any qualified provider. Members also have direct access to Women's Health Care Provider (WHCP) services. Members have the right to select their own women's health care provider, including staff midwives and Doulas participating in Aetna Better Health of Maryland's network, and can obtain maternity and routine gynecological care without prior approval from a PCP. COVID testing and vaccination does not require prior authorization. For other services not requiring prior approval, please access our provider portal where you may enter the code to determine if prior authorization is required.

There are surgical procedures which don't require prior authorization which may include an overnight stay in observation (24 hours). Any inpatient admission requires written notification within 24 hours.

Hospice providers, whether in network or not, are required to notify us in writing within 24 hours or the next business day of all admissions for home or inpatient services.

Prior Authorization Procedures
Generally, a member's PCP, or treating provider is responsible for initiating and coordinating a request for authorization. However, specialists and other providers may need to contact the Prior Authorization Department directly to obtain or confirm a prior authorization. Prior authorization requests for inpatient services must be submitted to the Aetna Better Health of Maryland's utilization management team within 24 hours of an inpatient admission. Prior authorizations should be submitted using methods outlined below.

The requesting provider is responsible for complying with Aetna Better Health of Maryland's prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims.

A prior authorization request must include the following:
Aetna Better Health of Maryland prior authorization form, which can be found on our website at **AetnaBetterHealth.com/Maryland/providers/forms.html**.

- Current, applicable codes may include:
  - Current Procedural Terminology (CPT)
  - International Classification of Diseases, 10th Edition (ICD-10)
  - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)

- Name, date of birth, sex, and identification number of the member
- Primary care provider or treating provider
- Name, address, phone and fax number and signature, if applicable, of the referring or provider (NPI)
- Name, address, phone and fax number of the consulting provider (NPI)
- Problem/diagnosis, including the ICD-10 code
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

All clinical information must be submitted with the original request.

Inpatient Admissions and Concurrent Review
All providers, whether in network or not, are required to notify us in writing and with supporting clinical notes for all admissions and inpatient services within 24 hours or the next business day of all emergent admissions and daily thereafter. Aetna Better Health of Maryland will authorize covered length of stay one day at a time based on the clinical information provided to support the continued stay. Additional information may be requested in order to make an informed determination and must be provided within 24 hours of the request. If the information is not received within 24 hours, an administrative adverse determination (i.e., a denial) will be issued. Hospice providers, whether in network or not, are required to notify us in writing within 24 hours or the next business day of all admissions.

Notice of Action Requirements
Aetna Better Health of Maryland provides the provider and the member with written notification i.e., Notice of Action (NOA) of any decision to deny, reduce, suspend, or terminate a prior authorization request, limits, or to authorize a service in the amount, duration or scope that is less than requested or denies payment, in whole or part, for a service.

The notice will include:

- The action that Aetna Better Health of Maryland has or intends to take
- The specific service denied, the specific reason for the action, customized to the member circumstances, and in easily understandable language to the member
- A reference to the benefit provision, guideline, or protocol or other similar criterion on which the denial decision was based
- The name and contact information for the physician or dentist that reviewed and denied the service
- Notification that, upon request, the provider or member, if applicable, may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- Notification that provider has the opportunity to discuss medical, Utilization Management denial decisions with a physician or other appropriate reviewer
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal
- An explanation of the appeals process, including the right to member representation (with the member's permission) and the timeframes for deciding appeals
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- The member's or provider (with written permission of the member) right to request a Medicaid Fair Hearing and instructions about how to request a Medicaid Fair Hearing
- A description of the expedited appeals process for urgent pre-service or urgent concurrent denials

- The circumstances under which expedited resolution is available and how to request it
- The member's right to request continued benefits pending the resolution of the appeal or pending a Medicaid Fair Hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these benefits
- Translation service information
- The procedures for exercising the member's rights

Continuation of Benefits
Aetna Better Health of Maryland will continue member's benefits during the appeal process if:

- The member or the provider files the appeal timely,
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized network provider,
- The original period covered by the original authorization has not expired, unless inadequate notice was given to allow a member a timely appeal
- The member requested continuation of benefits in writing within ten days of the date of the denial letter for those eligible who requested the Medicaid Fair Hearing Process, or the intended effective date of the HMO proposed action

Aetna Better Health of Maryland will continue the member's benefits until one of the following occurs:

- The member withdraws the appeal
- A Maryland Fair Hearing office issues a hearing decision adverse to the member
- The time period or service limits of a previously authorized service has been met

Hospital Emergency Services
In the case of an emergency medical condition, hospitals are not required to obtain prior authorization from the Aetna Better Health of Maryland prior to providing emergency services to members; provided, however, that upon admitting a member into the hospital, the hospital shall immediately notify Aetna Better Health of Maryland within 24 hours of the date of service or the next business day by contacting our Utilization Department at **1-866-827-2710** or via fax at **1-855-661-1967** in accordance with this manual.

Except for emergency services, coverage of all services rendered to members by hospital is subject to the Aetna Better Health of Maryland's sole determination of whether such service is a covered service under the applicable member contract.

In the event it is determined that an emergency medical condition does not exist with respect to a member who presented to the hospital, hospital must comply with all prior authorization requirements as set forth in this manual prior to providing any non-emergency services to a member.

The Hospital's failure to obtain all required prior authorizations for non-emergency services may, in Aetna Better Health of Maryland's sole discretion, result in the Plan's denial of payment for such services as set forth in the agreement. The hospital shall comply with this manual and the agreement in providing non-emergency services to members. The hospital acknowledges and agrees that Aetna Better Health of Maryland has the right to review the admission of any member for an emergency medical condition for appropriateness of continued stay in accordance with the manual.

Concurrent Review
Concurrent review is composed of clinical and non-clinical staff. The concurrent review clinician will perform a medical necessity review for each hospitalization. Hospital admissions will be reviewed and followed for discharge needs. Reviews are conducted daily so clinical notes are required to be submitted daily. When the level of care does not meet the criteria or guideline standards, the case will be referred to an Aetna Better Health of Maryland medical director for review and determination.

Concurrent review may be conducted on-site, telephonically or by fax. Pertinent clinical information that documents the level of care is required daily and should be submitted by the hospital within 24 hours of the date of service or the next business day. Clinical information needed with each review includes, but is not limited to, the following:

- Current symptoms, complaints, vital signs, diagnosis, etc.
- Attending and/or consulting physician notes
- Diagnostic test results
- Laboratory results
- Current orders/treatment
- Treatment plan
- Discharge needs

A decision is communicated within 72 hours of receipt of clinical information. The facility is sent written notification of any adverse determination.

Peer-to Peer Consultation
Our medical directors conduct clinical review and participate in the prior authorization and utilization review process. Requests may be submitted via phone to **833-459-1998**. They are available to discuss medical necessity review determinations with attending physicians or other ordering providers. We will notify practitioners/ providers in writing, that they may request a peer-to peer consultation to discuss the rationale used to make the denied authorizations with the medical director reviewer. Requests for a peer to peer must be done within three days of the adverse decision. Administrative denials are not subject to the peer-to-peer process.

Period of Preauthorization
Prior authorization numbers are valid for the date of service authorized or for a period not to exceed 60 days after the date of service authorized. Billed services must match authorized services and or level of care as mismatches will trigger medical note review. The member must be eligible for Medicaid and enrolled in Aetna Better Health of Maryland on each date of service. For information about how to verify member eligibility using our Provider Portal see Section VI.

How to Request Medical Prior Authorizations
A prior authorization request may be submitted by:

- Submitting the request through the 24/7 Secure Provider Web Portal at **https://apps.availity.com/availity/web/public.elegant.login** located on the Aetna Better Health of Maryland's website at **AetnaBetterHealth.com/Maryland/providers/portal.html**, or
- Fax the request form (available on our website) with supporting clinical notes to **1-855-661-1967** (Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Provider Secure Web Portal at **https://apps.availity.com/availity/web/public.elegant.login**, or call us at **1-866-827-2710**. The portal will allow you to check status, view history

If response for non-emergency prior authorization is not received within 15 days, please contact us at **1-866-827-2710**. *For further information about the Secure Web Portal, please review Section VI.*
Prior Authorization and Coordination of Benefits Aetna Better Health of Maryland **may not** refuse to preauthorize a service because the member has other insurance. Even if the service is covered by the primary payer, the provider must follow our prior authorization rules. Preauthorization is not a guarantee of payment. Except for prenatal care and Healthy Kids/EPSDT screening services, you are required to bill other insurers first. For these services, we will pay the provider and then seek payment from the other insurer.
Medical Necessity Criteria A "medically necessary" service or benefit must be:

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

Clinical Guidelines
To support prior authorization decisions, Aetna Better Health of Maryland uses nationally recognized, community developed, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Prior authorization staff members that make medical necessity determinations are trained on the criteria and the criteria is established and reviewed according to Aetna Better Health of Maryland policies and procedures.

For prior authorization of elective inpatient and outpatient medical services, Aetna Better Health of Maryland uses the following medical review criteria. Criteria sets are reviewed annually for appropriateness to the Aetna Better Health of Maryland's population needs and updated as applicable when nationally or community-based clinical practice guidelines are updated. The annual review process involves appropriate providers in developing, adopting, or reviewing criteria. The criteria are consistently applied, consider the needs of the members, and allow for consultations with requesting providers when appropriate. These are to be consulted in the order listed:

- Criteria required by applicable state or federal regulatory agency
- Applicable Milliman Guidelines (MCG) as the primary decision support for most medical diagnoses and conditions
- Aetna Better Health of Maryland Clinical Policy Bulletins (CPBs)
- Aetna Better Health of Maryland Policy Council Review

If MCG states "current role remains uncertain" for the requested service, the next criteria in the hierarchy, Aetna Better Health of Maryland CPBs, should be consulted and utilized.

Medical, criteria and practice guidelines are disseminated to all affected providers upon request and, upon request, to members and potential members.

Timeliness of Decisions and Notifications to Providers and Members

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

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

Aetna Better Health of Maryland will send notice to deny authorizations to providers and members:

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

Decision/Notification Requirements

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Within 72 hours of receipt of the request	Practitioner/ provider and member	Written notification (electronic and written) provider/member: Send written notification within 72 hours of receipt of request.
Urgent pre-service denial	Within 24 hours of the expedited authorization determination **and** within 72 hours of receipt of the request.	Practitioner/ provider and member	Written notification (electronic and written) provider/member: Send written notification within 24 hours of the expedited authorization decision
Non-urgent pre- service approval	Notification and decision: within two business days from receipt of the request when no additional information is needed and within 14 calendar days if additional information is required. Notification: within 72 hours from the decision		

Non-urgent pre-service denial	Decision: within two business days from receipt of the request when no additional information is needed and within 14 calendar days if additional information is required. Notification: within 72 hours from the decision	Practitioner/ provider and member	Electronic and written notification
Post-service approval	Within 30 calendar days of receipt of the request	Practitioner/ provider and member	Written notification (electronic and written) provider: Send notification within 30 calendar days from the receipt of the request. Member: Send notification within 30 calendar days of the receipt of the request.
Post-service denial	Within 30 calendar days of receipt of the request	Practitioner/ provider and member	Written notification (electronic and written) provider: Send notification within 30 calendar days from the receipt of the request. Member: Send notification within 30 calendar days of the receipt of the request.
Urgent concurrent approval	Both decision and notification within 72 hours of receipt of the request	Practitioner/ provider and member	Written notification (electronic and written) provider/member: Send written notification within 72 hours of receipt of request.
Urgent concurrent denial	Within 24 hours of the expedited authorization determination **and** within 72 hours of receipt of the request.	Practitioner/ provider and member	Electronic and written notification
Termination, suspension reduction of prior authorization	At least 10 calendar days before the date of the action	Practitioner/ provider and member	Electronic and written notification

Out of Network Providers

When approving a service from an out-of-network provider, Aetna Better Health of Maryland will assign a prior authorization number, which refers to and documents the approval. Prior authorization requests for inpatient services must be submitted to the Aetna Better Health of Maryland's utilization management team within 24 hours of an inpatient admission or the next business day and daily thereafter. Aetna Better Health of Maryland sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request. Refer to Section I for list of self-referred services which are services we must allow members to access out-of-network. Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Aetna Better Health of Maryland makes such decisions on a case-by-case basis.

Overview of Member Complaint, Grievance and Appeal Process

Aetna Better Health of Maryland's Member Services phone number is **1-866-827-2710**. Our hours of operation are Monday – Friday from 8 AM – 5 PM ET. Member services resolves or properly refers members' inquiries or complaints to the state other agencies. Aetna Better Health of Maryland informs members and providers of the grievance system processes for complaints, grievances, appeals, and Maryland State Fair Hearings. This information is contained in the Member Handbook and is available on the Aetna Better Health of Maryland website. When requested, we give members reasonable assistance in completing forms and taking other procedural steps. Our assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability at no cost to the member.

Members, or their authorized representative, can file an appeal or grievance with Aetna Better Health of Maryland orally or in writing. An authorized representative is someone who assists with the appeal on the member's behalf, including but not limited to a family member, friend, guardian, provider, or an attorney. Representatives must be designated in writing before or within 10 business days of filing. Providers will not be penalized for advising or advocating on behalf of an enrollee.

A network provider, acting on behalf of a member, and with the member's written consent, may file a standard appeal or grievance with Aetna Better Health of Maryland. A provider acting on behalf of a member may file an expedited appeal or grievance without written consent of the member. Members and their representatives including providers with written consent may also contact the HealthChoice Help Line at **1-855-642-8572**. Complaint Resolution will explain the State Fair Hearing process.

Members and their representatives may also request any of the following information from Aetna Better Health of Maryland, free of charge, to help with their appeal by calling **1-866-827-2710**:

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

Aetna Better Health of Maryland will take no punitive action for:

- Members requesting appeals or grievances
- Providers requesting expedited resolution of appeals or grievances
- Providers supporting a member's appeal or grievance
- Members or providers making complaints against Aetna Better Health of Maryland or the Department

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

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

MCO Member Grievance Procedures

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

Examples of reasons to file an administrative grievance include:

- The member's provider's office was dirty, understaffed, or difficult to access.
- The provider was rude or unprofessional.
- The member cannot find a conveniently located provider for their health care needs.
- The member is dissatisfied with the help he/she received from the provider's staff or Aetna Better Health of Maryland.

Examples of reasons to file a medical grievance include:

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

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

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

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

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

MCO Member Appeals Procedures

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

- Aetna Better Health of Maryland denies covering a service ordered or prescribed by the member's provider. The reasons a service might be denied include:
    - The treatment is not needed for the member's condition or would not help the provider in diagnosing the member's condition.
    - Another more effective service could be provided instead.
    - The service could be offered in a more appropriate setting, such as a provider's office instead of the hospital.
- Aetna Better Health of Maryland limits, reduces, suspends, or stops a service that a member is already receiving. For example:
    - The member has been getting physical therapy for a hip injury and he/she has reached the frequency of physical therapy visits allowed.
    - The member has been prescribed a medication, it runs out, and he/she does not receive any more refills for the medication.
- Aetna Better Health of Maryland denies all or part of payment for a service a member has received, and the denial was not related to the claim being "clean."
- Aetna Better Health of Maryland fails to provide services in a timely manner, as defined by the Department (for example, it takes too long to authorize a service a member or their provider requested).
- Aetna Better Health of Maryland denies a member's request to speed up (or expedite) the resolution about a medical issue.

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

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

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

When the member files an appeal, or at any time during our review, the member and/or provider should provide us with any new information that will help us make our decision. The member or representative may ask for up to 14 additional days to gather information to resolve the appeal. If the member or representative needs more time to gather information to help Aetna Better Health of Maryland make a decision, they may call Aetna Better Health of Maryland at **1-866-827-2710** and ask for an extension.

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

When reviewing the member's appeal, we will:

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

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

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

For an expedited appeal timeframe, Aetna Better Health of Maryland will communicate the decision verbally at the time of the decision and in writing, including an explanation for the decision, within 24 hours of the decision. If we decide that they should not receive the denied service, that letter will tell them how to ask for a State Fair Hearing.

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.

Members may file an appeal by:

Calling: Member Services at **1-866-827-2710**

Writing: Aetna Better Health of Maryland Grievance System Manager
PO Box 81139
5801 Postal Road
Cleveland, OH 44181
FAX: **1-844-312-4257**

Request to Continue Benefits During the Appeal

If the member's appeal is about a service that was already authorized and they were already receiving, they may be able to continue to receive the service while we review their appeal. Providers may not request to continue benefits on the member's behalf. The member should contact us within 10 days of receiving the denial notice at **1-866-827-2710** if they would like to continue receiving services while their appeal is reviewed. If the member does not win their appeal, they may have to pay for the services that they received while the appeal was being reviewed.

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

State Fair Hearing Rights

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

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.

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

State HealthChoice Help Lines

If a member has questions about the HealthChoice Program or the actions of Aetna Better Health of Maryland please direct them to call the state's HealthChoice Help Line at **1-800-284-4510**. Providers can contact the HealthChoice Provider Line at **1-800-766-8692**.

Section V

PHARMACY MANAGEMENT

Pharmacy Benefit Management
Aetna Better Health of Maryland is responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program prescription medications and certain over-the-counter medicines. This requirement pertains to new drugs or equivalent drug therapies, routine childhood immunizations, vaccines prescribed for high risk and special needs populations and vaccines prescribed to protect individuals against vaccine-preventable diseases. If a generic equivalent drug is not available, new brand name drugs rated as "P" (priority) by the FDA, will be added to the formulary.

Coverage may be subject to preauthorization to ensure medical necessity for specific therapies. For formulary drugs requiring preauthorization, a decision will be provided within 24 hours of request. When a prescriber believes that a non-formulary drug is medically indicated, we have procedures in place for non-formulary requests. The state expects a non-formulary drug to be approved if documentation is provided indicating that the formulary alternative is not medically appropriate. Requests for non-formulary drugs will not be automatically denied or delayed with repeated requests for additional information.

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

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

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

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

Aetna Better Health of Maryland contracts with CVS Health to provide the following services pharmacy network contracting, mail order delivery, specialty pharmacy services and network point-of-sale (POS) claim processing.

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

Aetna Better Health of Maryland offers mail order prescription services through CVS Caremark. Members can access this service in two ways.

1. By calling CVS Caremark, toll free at **1-855-271-6603, TTY: 711** (24 hours a day, 7 days a week). They will help the member sign up for mail order service. If the member gives permission, CVS Caremark will call the prescribing provider to get the prescription.
2. By requesting their provider to write a prescription for a 90-day supply with up to one year of refills. Then the member calls CVS Caremark and asks CVS Caremark to mail them a Mail Service order form. When the member receives the form, the member fills it out and mails CVS Caremark the prescription and the order form. Forms should be mailed to:
   CVS/Caremark PO BOX 2110
   Pittsburgh, PA 15230-2110
   Once a mail order is established, a member can log into the health plan secure member portal to access the **Caremark.com** link and have a mail order prescription refilled.

CVS Caremark Specialty Pharmacy
CVS Caremark Specialty Pharmacy is a pharmacy that offers medications for a variety of conditions, such as cancer, hemophilia, immune deficiency, multiple sclerosis, and rheumatoid arthritis, which are not often available at local pharmacies. Specialty medications require prior authorization before they can be filled and delivered. Providers can call **1-866-827-2710** to request prior authorization or complete the applicable prior authorization form and fax to **1-877-270-3298**.

Specialty medications can be delivered to the provider's office, member's home, or other location as requested.

Prescriptions and Drug Formulary
Check the current Aetna Better Health of Maryland formulary, located on our website, before writing a prescription for either prescription or over-the-counter drugs Aetna Better Health of Maryland members must have their prescriptions filled at a network pharmacy.

Most behavioral health medications are on the Specialty Mental Health System (SMHS) formulary and are paid by Medicaid not Aetna Better Health of Maryland. The state's Medicaid formulary can be found at: **https://client.formularynavigator.com/Search.aspx?siteCode=9381489506.**

Prescription copays
Aetna Better Health of Maryland has pharmacy copays of $3 for non- formulary brand name drugs, $1 for formulary brand name drugs, $1 for generic formulary/non-formulary drugs, and $1 for antiretroviral medications used for prevention or treatment of HIV/AIDS. Aetna Better Health of Maryland does not charge copays for children under age 21, pregnant women, individuals in hospice, American Indian tribe members, emergency 72-hour prescription fills, and for birth control. The state has pharmacy copays for drugs covered by the state, such as behavioral health drugs. Over-the-Counter Products, Injectables and Non-Formulary Medications Requiring Prior Authorization

Aetna Better Health of Maryland formulary is available on our website as a PDF and a searchable format. The formulary lists covered over-the-counter products, injectables and formulary medications that require prior authorization. Prior authorization guidelines are also available on our website. Any medication not listed on our formulary can be submitted for review via the prior authorization process.

Prior Authorization Process

Aetna Better Health of Maryland's pharmacy Prior Authorization (PA) processes are designed to approve only the dispensing of medications deemed medically necessary and appropriate. Our pharmacy PA process will support the most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit, and determining medical necessity. Typically, we require providers to obtain PA prior to prescribing or dispensing the following:

- Injectable dispensed by a pharmacy provider
- Exceptions for non-formulary drugs that are not excluded under a state's Medicaid program
- Prescriptions that do not conform to Aetna Better Health of Maryland's evidence-based utilization practices (e.g., quantity level limits, age restrictions or step therapy)
- Brand name drug requests, when an "A" rated generic equivalent is available

Aetna Better Health of Maryland's Medical Director is in charge of generating adverse decisions, including a complete denial or approval of a different medication. Using specific, evidence-based PA pharmacy review guidelines Aetna Better Health of Maryland's Medical Director will review the request and all supporting documentation prior to making a determination, as to the medical necessity of the drug requested. This supporting documentation information may include, but is not limited to, evidence indicating:

- Formulary alternatives have been tried and failed or cannot be tolerated (i.e., step therapy)
- There are no therapeutic alternatives listed in the formulary
- There is no clinical evidence that the proposed treatment is contraindicated (i.e., correctly indicated as established by the federal Drug Administration (FDA), or as accepted by established drug compendia)
- For brand name drug requests, a completed FDA MedWatch form documenting failure or intolerance to the generic equivalents is required

The prescribing provider and member will be appropriately notified of all decisions in accordance with regulatory requirements. Prior to making a final decision, our Medical Director may contact the prescriber to discuss the case or consult with a board-certified physician from an appropriate specialty area such as a psychiatrist.

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

Step Therapy and Quantity Limits

The step therapy program requires certain prerequisite drugs, such as generic drugs or formulary brand drugs, to be prescribed prior to approval of specific requested drugs. Drugs having step therapy are identified on the formulary with "STEP".

Certain drugs on the Aetna Better Health of Maryland formulary have quantity limits and are identified on the formulary with "QLL". The QLLs are established based on FDA-approved dosing levels and on national established/recognized guidelines pertaining to the treatment and management of the diagnosis it is being used to treat.

To request an override for the step therapy and quantity limit, please fax a Pharmacy Prior Authorization Request form and any supporting medical records that will assist with the review of the request to **1-877-270-3298.**

Maryland Prescription Drug Monitoring Program Aetna Better Health of Maryland complies with the Maryland Prescription Drug Monitoring Program. The Maryland Prescription Drug Monitoring Program (PDMP) is an important component of the Maryland Department of Health initiative to halt the abuse and diversion of prescription drugs.

The Maryland Department of Health is a statewide database that collects prescription data on Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH) dispensed in outpatient settings. The Maryland Department of Health does not collect data on any other drugs.

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

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

Corrective Managed Care Program

We restrict members to one pharmacy if they have abused pharmacy benefits. We must follow the state's criteria for **Corrective Managed Care**. The Corrective Managed Care (CMC) Program is an ongoing effort by the Maryland Medicaid Pharmacy Program (MMPP) to monitor and promote appropriate use of controlled substances. Call **1-866-827-2710** if a member is having difficulty filling a prescription. The CMC program is particularly concerned with appropriate utilization of opioids and benzodiazepines. Aetna Better Health of Maryland will work with the state in these efforts and adhere to the state's opioid preauthorization criteria.

Maryland Opioid Prescribing Guidance and Policies

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

Policy

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

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

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

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

Guidance:

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

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

Screening, Brief Intervention and Referral to Treatment (SBIRT), is an evidenced-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and drugs. The practice has proved successful in hospitals, specialty medical practices, emergency departments and workplace wellness programs. SBIRT can be easily used in primary care settings and enables providers to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work or family issues. The provision of SBIRT is a billable service under Medicaid. Information on billing may be accessed here: **https://mmcp.health.maryland.gov/MCOupdates/Documents/pt_43_16_edicaid_program_updates_for_spring_2016.pdf**

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

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

Patients identified with substance use disorder should be referred to substance use treatment. Maryland Medicaid administers specialty behavioral health services through a single Administrative Services Organization – Optum Maryland. If you need assistance in locating a substance use treatment provider, Optum Maryland may be reached at **1-800-888-1965**. If you are considering a referral to behavioral health treatment for one of your patients, additional resources may be accessed at: **https://maryland.optum.com**.

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

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

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

Section VI.

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

Facts to know before you bill
You must verify through the Eligibility Verification System (EVS) that participants are assigned to Aetna Better Health of Maryland before rendering services.

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

Submitting claims to Aetna Better Health of Maryland
Aetna Better Health of Maryland processes claims for covered services provided to members in accordance with applicable policies and procedures and in compliance with applicable state and federal laws, rules and regulations. Aetna Better Health of Maryland will not pay claims submitted by a provider who is not in good standing with the Maryland Department of Health.

Aetna Better Health of Maryland uses our business application system to process and adjudicate claims. Both electronic and manual claims submissions are accepted. To assist us in processing and paying claims efficiently, accurately and timely, Aetna Better Health of Maryland encourages providers to submit claims electronically. To facilitate electronic claims submissions, Aetna Better Health of Maryland has developed a business relationship with ECHO Health, Inc.. Aetna Better Health of Maryland receives electronic claims through our claims processing system directly from this clearinghouse, processes them through pre-import edits to maintain the validity of the data, HIPAA compliance, and member enrollment, and then uploads them into our business application each business day. Within 24 hours of file receipt, Aetna Better Health of Maryland provides production reports and control totals to trading partners to validate successful transactions and identify errors for correction and resubmission.

Billing inquiries
Aetna Better Health of Maryland is required to process claims in accordance with Medicaid claim payment rules and regulations.

Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes to the highest level of specificity. Complete and accurate use of The Centers for Medicare* Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the Risk Adjustment Processing System.

Important notes:

The ICD-10 CM codes must be coded to the highest level of specificity. Ie: assign three-digit codes only if there are no four- digit codes within that code category, assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory and assign the fifth-digit sub-classification code for those sub-categories where it exists.

Report all secondary diagnoses that impact clinical evaluation, management, and treatment. Report all relevant V-codes and E-codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Review of the medical record entry associated with the claim should obviously indicate all diagnoses that were addressed were reported.

Failure to use current coding guidelines may result in a delay in payment and rejection of a claim.

When and How to File Claims

When to file a claim – All claims and encounters must be reported to Aetna Better Health of Maryland, including any prepaid services.

Timely filing of claim submissions – In accordance with contractual obligations, claims for services provided to a member must be received in a timely manner. Our timely filing limitations are as follows:

- Claims must be submitted within 180 calendar days from the date of services. The claim will be denied if not received within the required timeframes.
- Providers have 180 days from the original date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not constitute reconsideration or claim dispute. Resubmission claims received trigger the reversal of the original paid claim to review current resubmission for processing.
- Coordination of benefits (COB) claims must be submitted within 60 days from the date of primary insurer's explanation of benefits (EOB) or 180 days from the date of service, whichever is later.
- Failure to submit claims and encounter data within the prescribed timeframe may result in payment delay or denial.

Non-network providers rendering prior authorized services must follow the same timely filing guidelines.

How to file a claim:

Select the appropriate claim form (refer to table below).

Service	
Medical and professional services	**CMS 1500 Form**
Hospital inpatient, outpatient, skilled nursing and emergency room services	**CMS UB-04 Form**
Dental services that are considered medical services (oral surgery, anesthesiology)	**CMS 1500 Form**
Skilled nursing facilities (SNFs)	**CMS UB-04 Form**
Home health claims	**CMS UB-04 Form**
Durable medical equipment (DME) rental claims	**CMS 1500 Form**
Same-day readmission	**CMS UB-04 Form**

Instructions on how to fill out the claim forms can be found on our website at **AetnaBetterHealth.com/Maryland**.

- Complete the claim form.
- Claims must be legible and suitable for imaging and microfilming for permanent record retention.
- Complete ALL required fields and include additional documentation when necessary.
- The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. This could result in the claim being denied for untimely filing.
- Submit original copies of claims electronically or through the mail (do NOT fax). To include supporting documentation, such as members' medical records, clearly label and send to Aetna Better Health of Maryland at the correct address.

Electronic Clearing House

Providers who are contracted with us can use electronic billing software. Electronic billing tends to be faster at processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim sent, and minimizes clerical data entry errors. Additionally, a Level Two report is provided to your vendor, which is the only accepted proof of timely filing for electronic claims.

ECHO Health, Inc. is the claims processing system vendor we use. Contact your software vendor directly for further questions about your electronic billing. Contact our Provider Services department for more information about electronic billing.

All electronic submissions will be submitted in compliance with applicable law including HIPAA regulations and Aetna Better Health of Maryland policies and procedures.

Through the mail

Claims	Mail To	Electronic Submission
Medical	Aetna Better Health of Maryland PO Box 982968 El Paso, TX 79998-2968	Through Electronic Clearinghouse

Correct coding initiative

Aetna Better Health of Maryland follows the same standards as Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit **www.cms.hhs.gov/NationalCorrectCodInitEd/**.

Aetna Better Health of Maryland utilizes ClaimCheck as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.

Clear Claim Connection is a web-based stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimCheck. It enables us to share with our providers the claim auditing rules and clinical rationale inherent in ClaimCheck.

Providers will have access to Clear Claim Connection through our website through a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct coding
Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure
- Are necessary to accomplish the comprehensive procedure
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure

Incorrect coding
Examples of incorrect coding include:

- Billing separate codes for related services when one code includes all related services
- Breaking out bilateral procedures when one code is appropriate
- Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate

Modifiers
Appropriate modifiers must be billed in order to reflect services provided and for claims to pay appropriately. Aetna Better Health of Maryland can request copies of operative reports or office notes to verify services provided.

Program-Accepted Modifiers

- The program recognizes two levels of modifiers: Level I modifiers found in CPT, and Level-II modifiers found in HCPCS, which are updated by CMS.
- Providers must report modifiers that affect processing and/or payment. Modifiers that affect processing and/or payment are included in the Appendix. There are additional modifiers that may affect pricing by individual consideration. Please refer to the Appendix for a list of program-accepted modifiers (see page 96).
- Example: **Modifiers -RT (right side) and -LT (left side) are not acceptable substitutes for modifier -50 (bilateral), and will not process correctly.**
- For additional guidance, please reference the Professional Services Provider Manual at https://health.maryland.gov/mmcp/pages/provider-information.aspx

Common Modifier Issue Clarification:
Modifier 59 – distinct procedural services – must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261-77499).

Modifier 25 – Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service – must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with Evaluation and Management codes and cannot be billed with surgical codes.

Modifier 50 – Bilateral procedure – if no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. We follow the same billing process as CMS and HFS when billing for bilateral procedures. Services should be billed on one-line reporting one unit with a 50 modifier.

Modifier 57 – Decision for surgery – must be attached to an evaluation and management code when a decision for surgery has been made. We follow CMS guidelines regarding whether the evaluation and management will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, Chapter 12 – Physicians/Non-physician Practitioners indicate:

"*Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier "-57" to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier "-57" if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period."* Please refer to your Current Procedural Terminology (CPT) Manual for further detail on all modifier usage.

Need more help?

- Call **1-800-527-8133,** option 2, for questions about:
    - Submitting claims
    - Eligibility
    - Claim status

Checking Status of Claims

Providers may check the status of a claim by accessing our secure online Availity Provider Portal at **www.aetnabetterhealth.com/maryland/providers/portal.html** or by calling the Claims Inquiry Claims Research (CICR) department. To check the status of a disputed, resubmitted, or reconsidered claim, please contact the CICR department.

Online status through Aetna Better Health of Maryland's secure website

Aetna Better Health of Maryland encourages providers to take advantage of using our online Availity Provider Secure Web Portal at **www.aetnabetterhealth.com/maryland/providers/portal.html**. The online portal is quick, convenient and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic. The link to our online Availity Provider Portal is located on the website. Providers must register to use our portal. Please see Chapter 4 for additional details surrounding the secure online Provider Portal.

Calling the Claims Inquiry Research Department

The Claims Inquiry Claims Research (CICR) department is available to:

- Answer questions about claims
- Assist in resolving problems or issues with a claim
- Provide an explanation of the claim adjudication process
- Help track the disposition of a particular claim

Correct errors in claims processing:

- Excludes corrections to prior authorization numbers (providers must call the Prior Authorization department directly).
- Excludes rebilling a claim (the entire claim must be resubmitted with corrections)
- Please be prepared to give the service representative the following information:
    - Provider name or national provider identification (NPI) number with applicable suffix if appropriate
    - Member name and member identification number
    - Date of service
    - Claim number from the remittance advice on which you have received payment or denial of the claim

Provider Disputes & Claims Resubmission

Providers have 180 days from the date of service to resubmit a revised version of a processed claim. The review and reprocessing of a claim does not constitute reconsideration or claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors

Include the following information when filing a resubmission:

- Use the Provider Dispute & Claim Resubmission Form located on our website at https://www.aetnabetterhealth.com/maryland/providers/forms.html
- An updated copy of the claim. All lines must be rebilled. A copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required
- A brief note describing requested correction

Clearly label as "Resubmission" at the top of the claim in black ink and mail to appropriate claims address.

Resubmissions may not be submitted electronically. Failure to mail and accurately label the resubmission to the correct address will cause the claim to deny as a duplicate.

Please note: Providers will receive an EOB when their disputed claim has been processed. Providers may call our CICR department during regular office hours to speak with a representative about their claim dispute. The CICR department will be able to verbally acknowledge receipt of the resubmission, reconsideration, and the claim dispute. Our staff will be able to discuss, answer questions, and provide details about status. Providers can review our Secure Web Portal to check the status of a resubmitted/reprocessed or adjusted claim. These claims will be noted as "Paid" in the portal. To view our portal, please click on the portal tab, which is located under the provider page, which can be found on our website, **AetnaBetterHealth.com/Maryland**.

Remittance Advice

Provider remittance advice

Aetna Better Health of Maryland generates checks twice a week. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to verify proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Call our Provider Services department if you are interested in receiving electronic remittance advices.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of Maryland for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment depending on the terms of the provider contract.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health of Maryland due to overpayment. These are listed to identify claims that have been reversed. The reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of REVERSED in the claim detail header with a non-zero Refund Amount listed.

- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health of Maryland after this payment cycle. This will result in a negative Amount Paid.
- The Check number and Check Amount are listed if there is a check associated with the remit. If payment is made electronically then the Electronic Funds Transfer (EFT) Reference number and EFT Amount are listed along with the last four digits of the bank account, the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.
- The Benefit Plan refers to the line of business applicable for this remit. Tax Identification Number (TIN) refers to the tax identification number.
- The Claim Header area of the remit lists information pertinent to the entire claim. This includes:
  - Member name
  - ID
  - Birth date
  - Account number
  - Authorization ID, if obtained
  - Provider name
  - Claim status
  - Claim number
  - Refund amount, if applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information as well as grievance rights information.

An electronic version of the Remittance Advice can be obtained. In order to qualify for an Electronic Remittance Advice (ERA), you must currently submit claims through the claims processing system and receive payment for claim by EFT. You must also have the ability to receive ERA through an 835 file. We encourage our providers to take advantage of the claims processing system, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact our Provider Services department for assistance with this process. Payment for the Program will be made on separate checks, one check from Medicare and one check from Medicaid.

Claims submission/claims filing formats

Providers can elect to file claims with Aetna Better Health of Maryland in either an electronic or a hard copy format. Claims must be submitted using either the CM 1500 or UB 04 formats, based on your provider type as detailed below.

Electronic claims submission

In an effort to streamline and refine claims processing and improve claims payment turnaround time, Aetna Better Health of Maryland encourages providers to electronically submit claims, through ECHO Health, Inc. .

Please use the Payer ID number **128MD** when submitting claims to Aetna Better Health of Maryland for both CMS 1500 and UB 04 forms. You can submit claims by visiting Change Healthcare ECHO Health, Inc. at **www.echohealthinc.com**. Before submitting a claim through your clearinghouse, please verify that your clearinghouse is compatible with ECHO Health, Inc.

Important points to remember

- Aetna Better Health of Maryland does not accept direct submissions in the claims processing system from its providers.
- Aetna Better Health of Maryland does not perform any 837 testing directly with its providers but performs such testing with ECHO Health, Inc.
- For electronic resubmissions, providers must submit a frequency code of seven or eight. Any claims with a frequency code of five will not be paid.

Paper claims submission

Providers can submit hard copy CM 1500 or UB 04 claims directly to us via mail to the following address:

Aetna Better Health of Maryland
P.O. Box 982968
El Paso, TX 79998-2968

Provider Appeal of Aetna Better Health of Maryland Claim Denial

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

Aetna Better Health of Maryland's Provider Complaint System offers an impartial process for resolving provider requests to reconsider a decision. A provider may file an appeal with Aetna Better Health of Maryland when the provider's appeal or grievance is not resolved to the provider's satisfaction, or when Aetna Better Health of Maryland acts to reduce, suspend, or terminate a provider's privileges with the health plan. Aetna Better Health of Maryland will respond to provider appeals pursuant to the guidelines in this policy. Upon completion of Aetna Better Health of Maryland appeal process the provider can file an independent review request with the state's independent review organization (IRO).

In addition, contracting and non-contracting providers may file an appeal directly with Aetna Better Health of Maryland verbally or in writing in regard to Aetna Better Health of Maryland denial or payment of a claim. Verbal requests may be required to be submitted in writing.

Aetna Better Health of Maryland will make sure that no punitive action is taken against a provider who files a claim appeal. A dispute between a provider and Aetna Better Health of Maryland will not disrupt or interfere with the provisions of services to the member. Aetna Better Health of Maryland will administer an equitable, timely, and balanced review of provider appeal.

A trained and qualified Appeal and Grievance manager assumes primary responsibility for coordinating and managing provider appeals and for disseminating information to the provider about the status of the appeals.

Regardless of the department in which the information originates, all appeals are documented within Aetna Better Health of Maryland's call system and submitted on the date of receipt, with supporting documentation, to the Appeal and Grievance Department. The Appeal and Grievance Coordinator documents the appeal in the Appeal and Grievance application for tracking, review, referral, resolution, and reporting.

Providers may submit a:

- Level I Provider Appeal either verbally or in writing within 90 business days from the date of an adverse determination in the provider claim dispute process.
- Level II Provider Appeal may be submitted within 15 business days of the date on the adverse determination in the Level I Provider Appeal process.

Verbal submissions may be required to be communicated in writing. Aetna Better Health of Maryland will acknowledge all verbal requests verbally at the time of receipt and will acknowledge written requests in writing within five business days. The acknowledgment will include instructions on how to:

- Revise the appeal within the timeframe specified in the acknowledgement letter
- Withdraw an appeal at any time until Appeal Committee review

The Appeal and Grievance department is designated to receive provider claim appeals, documenting the substance of individual appeals, coordinating resolutions, tracking data and reviewing appeals for trends in quality of care or other service-related issues.[4] If the appeal requires research or input by another department, the Appeal and Grievance Department will forward the information to the affected department and coordinate with the affected department to thoroughly research each appeal using applicable statutory, regulatory, and contractual provisions whereas appropriate collecting pertinent facts from all parties and applying the Aetna Better Health's written policies and procedures. The appeal with all research will be presented to the Appeal Committee for decision.

The Appeal Committee will include a provider with same or similar specialty if the appeal is related to a clinical issue as well as an officer of the plan who has the authority to require corrective action. Aetna Better Health of Maryland will confirm that the individual(s) who make decisions on appeals either individually or through appeal committee are individual(s) who were not involved in any previous level of review or decision-making and if deciding an appeal of a denial, reduction, termination or suspension that is based on lack of medical necessity or an appeal that involves other clinical issues are health care professionals who have the appropriate training and clinical expertise, as determined by NCQA and the state agency, in the field of medicine treating the member's condition or disease or who has experience treating the member's condition or disease or treating similar complications related to the member's condition or disease.

- Clinical appeal considerations are conducted by health professionals who:
  - Are clinical peers
  - Would typically manage the medical, procedure, or treatment in their practice that is the subject of the appeal
  - Hold an active, unrestricted license to practice medicine or a health profession.
  - Are board-certified (if applicable) by
    - A specialty board approved by the American Board of Medical Specialties (Doctor of Medicine)
    - The Advisory Board of Osteopathic Specialists from the major areas of clinical services (Doctor of Osteopathic Medicine)

  Aetna Better Health of Maryland will appoint at least one person to review the appeal who is a practitioner in the same or a similar specialty as typically manages the medical, procedure, or treatment in question in the appeal. All same specialty review recommendations are presented to the appropriate person, persons member's condition or disease or who has experience treating the member's condition or disease or treating similar complications related to the member's condition or disease.

[4] COMAR 10.67.09.03.B (7) (i)

The Appeal Committee will consider the additional information and will decide the appeal.

All data collected is reported to the Appeal Committee, Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC) at least quarterly (more frequently if appropriate) summarizing the frequency and resolution of all appeals for identification of opportunities for improvement as well as follow up on identified actions to address those opportunities.

All levels of provider appeals will be reviewed and resolved within 90 business days of receipt of the initial appeal by Aetna Better Health.

- Level I Provider Appeal must be filed with Aetna Better Health of Maryland within 90 business days from the date of original denial and will be resolved within 30 business days of receipt.
- Level II Provider Appeals must be filed with Aetna Better Health of Maryland within fifteen (15) business days of the date of the notification upholding the denial of a Level 1 Provider Appeal and will be resolved within 30 business days of receipt.

Aetna Better Health of Maryland will generate a written decision notice to the provider via electronic mail, fax or surface mail timely within three business days of the decision and within the 30 business days permitted for processing the Level I and Level II health plan appeals. The timeframe for resolution may not be extended. Aetna Better Health of Maryland will process a claim to pay within 30 calendar days of the date on the notification letter informing the provider the appeal decision was overturned.

Aetna Better Health of Maryland will retain all appeals files in a secure, designated area for a period of at least 10 years following the final decision and for 10 years post age 21 for cases involving associated members younger than 21 years old.

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

MCO Quality Initiatives

Aetna Better Health of Maryland maintains quality management (QM) through a Quality Assessment and Performance Improvement (QAPI) program. This involves multiple organizational components and committees. The primary goal of the QM program is to improve the health status of members – or maintain current health status when the member's condition is not amenable to improvement. Aetna Better Health of Maryland's QAPI program is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities. These activities continuously and proactively review our clinical and operational programs and processes to identify opportunities for improvement.

Provider Performance Data
Aetna Better Health of Maryland uses the provider performance data to monitor practitioners' service provision and utilization and cost trends; to identify opportunities for care delivery improvement; to promote member care management and care coordination; and to support achievement of HEDIS® targets.

Pay for Performance
Through development of value based service (VBS) arrangements Aetna Better Health of Maryland will incentivize providers to focus and deliver improved clinical, functional and quality outcomes for our members. We will incentivize and reward providers who demonstrate their ability to lower costs and improve health outcomes through enhanced care coordination, improved discharge planning between inpatient and outpatient providers and, improved communication, data sharing and communication between acute care and behavioral health service providers.

Section VII

PROVIDER SERVICES & RESPONSIBILITIES

Overview of Provider Services

Our Provider Services Department functions as a liaison between Aetna Better Health of Maryland and the provider community. Our staff is comprised of Network Managers, Provider Liaisons, and Provider Service Representatives. Our Network Managers conduct onsite and remote provider training, problem identification and resolution, provider office visits, and accessibility audits.

Our Provider Services Representatives are available by phone or email to provide telephonic or electronic support to all providers. Below are some of the areas in which we assist:

- Provide education to provider offices.
- Provide orientation to new providers.
- Provide support on Medicaid policies and procedures.
- Clarify provider contract provisions.
- Educate provider on compliance in respond to member's complaint from grievance & appeals.
- Assist with demographic changes, terminations, and initiation of credentialing.
- Conduct member complaint investigation.
- Maintain the provider directory.
- Assist practices to obtain secure web portal or member care login information.
- Be a point of contact for provider concerns and claims issues

The Provider Relations team is responsible for the ongoing education and training of Aetna Better Health's provider community. We maintain a strong commitment to meeting the needs of our providers. To accomplish this, a Provider Relations Manager is assigned to specific groups of participating providers. This process allows each office to become familiar with its representative and form a solid working relationship. Each provider representative has a thorough understanding of our health plan operations and is well versed in the managed care program.

Important Contacts	Phone Number	Facsimile	Hours and Days of Operation (excluding Maryland holidays)
Aetna Better Health of Maryland	**1-866-827-2710** (follow the prompts to reach the appropriate departments) Provider Services department Member Services department (eligibility verifications-secure web portal, accessible via our website **AetnaBetterHealth.com/Maryland**	Individual departments are listed below	8 AM-5 PM ET Monday-Friday 8 AM-5 PM ET Monday-Friday 24 hours / 7 days per week
Aetna Better Health of Maryland – Care Management	**1-866-827-2710** (follow the prompts to reach the appropriate departments)	**1-866-830-0088**	
Aetna Better Health of Maryland Prior Authorization Department	See program numbers above and follow the prompts	**1-855-661-1967**	24 hours / 7 days per week
Aetna Better Health of Maryland Compliance Hotline (reporting fraud, waste or abuse)	**1-855-877-9735** **AetnaBetterHealthMaryland_Fraud_Abuse.com**	N/A	24 hours / 7 days per week through voice mail inbox
Aetna Better Health of Maryland Special Investigations Unit (SIU) (reporting fraud, waste or abuse)	**1-800-338-6361** **AetnaBetterHealthMaryland_Fraud_Abuse.com**	N/A	24 hours / 7 days per week

Availity provider portal

The Availity provider portal offers secure online access for multiple health plans, and the ability to manage business transactions through a single, easy-to-use site. Registering for the provider portal will also allow you to set up EDI Gateway, batch, and FTP services (or transactions). All you need is basic information about your business, including your federal tax ID.

Providers already registered with Availity can log in with your regular credentials and choose Aetna Better Health of Maryland from your list of payers. This allows you to start using the portal and all its features. The portal tools make all your admin work as easy as possible.

Availity features

- **Electronic transactions** provide a secure platform where providers can submit ANSI, HIPAA, and HL7 transactions, as well as perform eligibility and benefit inquires, check claim status, and track remittances.
- **Multi-payer portal** ensures a consistent workflow for all participating health plans, which allows providers to have the same user experience.
- **Standard payer content for transactions consistent across all health plans and the opportunity to leverage Payer Spaces for branded, plan-specific content.**
- **Robust infrastructure** allows health plans to capture, store, and access critical information without having to invest in significant technology investments in their own storage technology.

Availity internet requirements

- High speed internet connection
- Internet Explorer 11.0®, Google Chrome, Microsoft Edge (version 79 or higher), or Firefox® browsers
- The ability to enable pop-up windows, allow JavaScript, and allows images to load automatically
- 1024 x 768 pixels or greater screen resolution
- Up-to-date antivirus software
- The latest version of Adobe® Reader, to view PDF forms

New to Availity?

Need help with registration? You can register online at **registration**. For assistance, just call Availity at **1-800-282-4548**. They can help from 8 AM to 8 PM ET, Monday through Friday (except holidays).

The following information can be attained from the Availity Provider Portal:

- Member Eligibility Search – Verify current eligibility of one or more members
- Panel Roster – View the list of members currently assigned to the provider as the PCP
- Provider List – Search for a specific provider by name, specialty, or location
- Claims Status Search – Search for provider claims by member, provider, claim number, or service dates. (Only claims associated with the user's account provider ID will be displayed.)
- View EOB – Download EOB/remit within the Claim Status multi-payer application by claim number. (Only remits associated with the user's account provider ID will be displayed.)
- Submit an Appeal or Grievance
- Check the status of a submitted Appeal or Grievance
- Claims Dispute Form – Submit an online form to the Aetna Better Health Claims Team to investigate any claim disputes.
- View Claim Dispute Form through EDI – Providers may view claim dispute forms submitted through the secure web portal if they also have access to EDI.
- Provider Prior Authorization Look up Tool – Search for provider authorizations by member, provider, authorization data, or submission/service dates. (Only authorizations associated with the user's account provider ID will be displayed.) Search Prior Authorization requirements by individual or multiple Current Procedural Terminology/Healthcare Common Procedures Coding System (CPT/HCPCS) codes simultaneously.

- Review Prior Authorization requirement by specific procedures or service groups
- Receive immediate details as to whether the codes are valid, expired, a covered benefit, have prior authorization requirements, and any noted prior authorization exception information
- Export CPT/HCPS code results and information to Excel
- Ensure office staff works from the most up-to-date information on current prior authorization requirements
- Submit an authorization request online. Three types of authorization types are available:
  - Medical Inpatient
  - Outpatient
  - Durable medical equipment – rental
- Healthcare effectiveness data and information set (HEDIS) – Check the status of the member's compliance with any of the HEDIS measures. A "Yes" means the member has measures that they are not compliant with; a "No" means that the member has met the requirements.

For additional information regarding the Availity provider portal, please access the provider portal page located on our website **aetnabetterhealth.com/maryland/providers/portal.html**

Provider Inquires
Providers may contact Aetna Better Health of Maryland at **1-866-827-2710** between the hours of 8 AM and 5 PM, Monday through Friday, or email at **MarylandProviderRelationsDepartment@aetna.com** for any questions, including checking on the status of an inquiry. Our Provider Services staff will respond within 48 business hours.

Re-Credentialing
Aetna Better Health of Maryland uses current NCQA standards and state guidelines for the recredentialing of providers and uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource for all provider types. The Universal Credentialing DataSource was developed by America's leading health plans collaborating with CAQH. The Universal Credentialing DataSource is the leading industry-wide service to address one of providers' most redundant administrative tasks: the credentialing application process. Paper applications can be obtained by contacting Provider Services at **1-866-827-2710**.

Providers are recredentialed every three years and must complete the required reappointment application. Updates on malpractice coverage, state medical licenses, and DEA certificates are also required. Please note that providers may NOT treat members until they are credentialed. Providers may contact Aetna Better Health of Maryland at **1-866-827-2710** between the hours of 8 AM and 5 PM, Monday through Friday, or e-mail at **ABHMDCredentialing@aetna.com** for all questions including checking the initial or recredentialing status of a provider.

Providers interested in joining Aetna Better Health of Maryland's network

If you are interested in applying for participation in our Aetna Better Health of Maryland network, please visit our website at **https://www.aetnabetterhealth.com/maryland/providers/join-network.html.** To determine if Aetna Better Health of Maryland is accepting new providers in a specific region, please contact our Provider Services Department at the number located above.

If you would like to mail your application, please mail to:

Aetna Better Health of Maryland
Attention: Provider Services
104320 Little Patuxent Parkway, Suite 600
Columbia, Maryland 21044

Please note this is for all medical types of providers including (specialists, primary care, hospitals, ancillary services, FQHCs, etc.)

Information changes

Providers are responsible for notifying our Provider Services Department regarding any changes in professional staff at their offices (physicians, physician assistants, or staff practitioners). Administrative changes in office roster staff may result in the need for additional training. Contact Provider Relations at **ABHMDNetworkRelations@aetna.com** to schedule staff training.

Providers terminating their contracts without cause are required to provide a **90-day written notice** before terminating with Aetna Better Health of Maryland. Providers must also continue to treat our members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. Aetna Better Health of Maryland is not responsible for payment of services rendered to members who are not eligible. You may also contact our Care Management Department for assistance.

Licensure & accreditation

Health delivery organizations such as hospitals, skilled nursing facilities, home health agencies, and ambulatory surgical centers must submit updated licensure and accreditation documentation at least annually or as indicated.

Overview of Provider Responsibilities

This section outlines general provider responsibilities; however, additional responsibilities are included throughout this manual. These responsibilities are the minimum requirements to comply with contract terms and all applicable laws. Providers are contractually obligated to adhere to and comply with all terms of the Maryland Medicaid Program, your provider agreement, and requirements outlined in this manual. Aetna Better Health of Maryland may or may not specifically communicate requirements in forms other than your Provider Agreement and this manual.

Providers must cooperate fully with state and federal oversight and prosecutorial agencies. This includes, but is not limited to, the Maryland Department of Health, The Maryland Office of Inspector General Center for Program Integrity (CPI), Health and Human Services – Office of Inspector General (HHS-OIG), Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), and the U.S. Attorney's Office.

Providers must act lawfully in the scope of:

- Practice of treatment
- Management
- Discussion of the medically necessary care

- Advising or advocating appropriate medical care with or on behalf of a member
- Providing information regarding the nature of treatment options
- Risks of treatment
- Alternative treatments
- Availability of alternative therapies
- Alternative consultation or tests that may be self-administered, including all relevant risk, benefits, and consequences of non-treatment.

Providers must also use the most current diagnosis, treatment protocols, and standards established by the Maryland Department of Health and the medical community. Advice given to potential or enrolled members should always be given in the best interest of the member. Providers may not refuse treatment to qualified individuals with disabilities, including but not limited to individuals with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS).

Unique Identifier/National Provider Identifier
Each provider must have a national provider identifier (NPI) on or after the compliance date established by the Centers for Medicare and Medicaid Services (CMS).

Appointment availability standards
The table below shows the standard appointment wait times for primary and specialty care. The table also reflects the standard for acceptable wait time in the office when a member has a scheduled appointment.

Acceptable appointment wait time standards

Provider Type	Emergency Services	Urgent Care	Non-Urgent	Preventive & Routine Care	Wait Time in Office Standard
Primary care provider (PCP)	Same day	Within 48 hours	Within 72 hours	Within 3 weeks	No more than 60 minutes
Specialty referral	Within 24 hours	Within 48 hours of referral	Within 72 hours	Within 4 weeks	No more than 60 minutes
Lab and radiology services	N/A	Within 48 hours	N/A	Within 3 weeks	N/A

Non-symptomatic office visits will include, but will not be limited to, well/preventive care appointments, such as annual gynecological examinations, or pediatric and adult immunization visits.

Physicals	
Baseline physicals for new adult members	Within 90 calendar days of initial enrollment.
Baseline physicals for new children members and adult clients of DDD	Within 90 days of initial enrollment, or in accordance with early periodic screening, diagnosis, and treatment (EPSDT) guidelines.
Routine physicals	Within 4 weeks for routine physicals needed for school, camp, work, or similar.
Family planning services	Within 10 business days of request
Prenatal care: Members will be seen within the following timeframes:	
Ten days of request	
Initial:	
Initial pediatric appointments	Within 30 days unless member is up to date with all Healthy Kids/EPSDT requirements then schedule according to schedule.
Supplemental Security Income (SSI)	Each new member will be contacted within 45 days of enrollment and offered an appointment date according to the needs of the member, except that each member who has been identified through the enrollment process as having special needs will be contacted within 10 business days of enrollment and offered an expedited appointment.
If a member has a health need identified at the time of enrollment (members are asked to complete the health service needs information at the time of enrollment which is transmitted to the MCO.)	Within 15 days

Aetna Better Health of Maryland waiting time standards require that members, on average, should not wait at a PCP's office for more than 60 minutes for an appointment for routine care. On rare occasions, if a PCP encounters an unexpected urgent visit or is treating a member with difficult medical needs, the waiting time may be extended to more than 60 minutes. The above access and appointment standards are provider contractual requirements. Aetna Better Health of Maryland monitors compliance with appointment and waiting time standards and works with providers to assist them in meeting these standards.

Telephone accessibility standards

Providers have the responsibility to plan for after-hours coverage in accordance with applicable Maryland and federal regulations, either by being available or having on-call arrangements in place with other qualified participating Aetna Better Health of Maryland providers for the purpose of rendering medical advice, determining the need for emergency; and other after-hours services including, authorizing care, and verifying member enrollment with the Plan.

It is our policy that network providers cannot substitute an answering service as a replacement for establishing appropriate on-call coverage. On-call coverage response for routine, urgent, or emergent health care issues are held to the same accessibility standards, regardless of whether after-hours coverage is managed by the PCP, current service provider, or the on-call provider.

All providers must have a published after-hours telephone number and maintain a system that will provide access to primary care 24 hours a day, 7 days a week. In addition, we will encourage our providers to offer open access scheduling, extended hours, and alternative options for communication (e.g., scheduling appointments via the web or communication via e-mail) between members, their PCPs, and practice staff. We will routinely measure the PCP's compliance with these standards as follows:

- Our medical and provider management teams will evaluate emergency room data to determine if there is a pattern where a PCP fails to comply with after-hours access or if a member may need care management intervention.
- Our compliance and provider management teams will evaluate member, caregiver, and provider grievances for after-hour access to care to determine if a PCP is failing to comply on a monthly basis.

Providers must comply with telephone protocols for all the following situations:

- Answering the member's telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment, (e.g., wheelchair and interpretive linguistic needs)
- Triage for medical and dental conditions and special behavioral needs for noncompliant individuals who are mentally deficient

Response time for telephone call-back waiting times: after hours telephone care for non-emergent, symptomatic issues – within 60 minutes; same day for non-symptomatic concerns; 15 minutes for crisis situations.

Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental personnel to provide covered services within normal working hours. Protocols will be in place to provide coverage in the event of a provider's absence.

A telephone response should be considered acceptable/unacceptable based on the following criteria:
Acceptable – An active provider response, such as:

- Telephone is answered by provider, office staff, answering service, or voice mail.
- The provider's answering machine message provides a telephone number to contact the provider/ covering provider.
- The answering service either:
  - Connects the caller directly to the provider.
  - Contacts the provider on behalf of the caller and the provider returns the call within 60 minutes.
  - Provides a telephone number where the provider/covering provider can be reached.

Unacceptable:

- The answering service:
  - Leaves a message for the provider on the PCP/covering provider's answering machine
  - Responds in an unprofessional manner

- The provider's answering machine message:
  - Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergency situations Instructs the caller to leave a message for the provider
  - No answer
- Listed number no longer in service
- Provider no longer participating in the contractor's network
- On hold for longer than five minutes
- Answering service refuses to provide information for survey
- Telephone lines persistently busy despite multiple attempts to contact the provider

Providers must make certain that their hours of operation are convenient to, and do not discriminate against, members. This includes offering hours of operation that are no less than those for non-members, commercially insured, or public fee-for-service individuals.

If a PCP fails to meet telephone accessibility standards, a Provider Services Representative will contact the provider to inform them of the deficiency, educate the provider regarding the standards, and work to correct the barrier to care.

Covering providers
Our Provider Services Department must be notified if a covering provider is not contracted or affiliated with Aetna Better Health of Maryland. This notification must occur in advance of providing authorized services. Depending on the Program, reimbursement to a covering provider is based on the fee schedule. Failure to notify our Provider Services Department of covering provider affiliations may result in claim denials and the provider may be responsible for reimbursing the covering provider.

Verifying member eligibility
All providers, regardless of contract status, must verify a member's enrollment status prior to the delivery of non-emergent, covered services. A member's assigned provider must also be verified prior to rendering primary care services. Providers are NOT reimbursed for services rendered to members who lost eligibility.

Member eligibility can be verified through one of the following ways:

- **Online eligibility verification tool –** Providers can verify member eligibility (up to five members at a time) via our Availity Provider Portal. Eligibility information is provided in real time and eligibility information can be downloaded for record keeping. Visit our website at **AetnaBetterHealth.com/Maryland** or contact our Provider Services Department for additional information about securing a confidential password to access the tool.
- **Monthly roster:** Monthly rosters are found on the Secure Web Portal. Contact our Provider Services Department for additional information about securing a confidential password to access the site. Note: rosters are only updated once a month.
- **Telephone verification:** Call our Member Services department to verify eligibility at **1-866-827-2710**. To protect member confidentiality, providers are asked for at least three pieces of identifying information such as the members identification number, date of birth and address before any eligibility information can be released.

Preventive or screening services
Providers are responsible for providing appropriate preventive care to members. These preventive services include, but are not limited to:

- Age-appropriate immunizations, disease risk assessment and age-appropriate physical examinations.
- Well woman visits (female members may go to a network obstetrician/gynecologist for a well woman exam once a year without a referral)
- Age and risk appropriate health screenings.
- For children follow the Maryland EPSDT/Healthy Kids Preventive Schedule and ACIP Immunization Schedule. See MDH website.
- For adults, follow the recommendations of the U.S. Preventive Services Task Force

Laboratory & radiology results
Providers are responsible for notifying members of laboratory and radiology results within 24 hours of receipt of results in urgent or emergent cases. You may arrange an appointment to discuss laboratory/radiology results within 24 hours of receipt of results, when it is deemed face-to-face discussion with the member/authorized person may be necessary. Urgent/emergency appointment standards must be followed. Rapid strep test results must be available to the member within 24 hours of the test.

Routine results: Providers are required to establish a mechanism to notify members of non-urgent or non-emergent laboratory and radiology results within ten business days of receipt of the results.

Educating members on their own health care
Aetna Better Health of Maryland does not prohibit providers from acting within the lawful scope of their practice and encourages them to advocate on behalf of a member and to advise them on:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- Any information the member needs in order to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Emergency services
Emergency services do not require preauthorization. In an emergency, please advise the member to go to the nearest emergency department. If a provider is not able to provide services to a member who needs urgent or emergent care, or if they call after hours, the member should be referred to the closest in-network urgent care or emergency department.

Urgent care services
As the provider, you must serve the medical needs of our members; you are required to adhere to all appointment availability standards. In some cases, it may be necessary for you to refer members to one of our network urgent care centers (after hours in most cases). Please reference the "Find a Provider" link on our website and select an "urgent care facility" in the specialty drop down list to view a list of participating urgent care centers located in our network.

Periodically, Aetna Better Health of Maryland will review unusual urgent care and emergency department utilization. Trends will be shared and may result in increased monitoring of appointment availability.

Primary Care Providers (PCPs)
The PCP serves as the entry point for access to health care services. The PCP is responsible for providing members with medically necessary covered services, or for referring a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member. Members can choose a physician, nurse practitioner or physician's assistant as their PCP. The PCP will act as a care coordinator and is responsible for providing accessible, comprehensive, and coordinated health care services covering the full range of benefits.

The PCP is required to:

- Address the member's general health needs
- Treat illnesses
- Maintain the member's health records
- Provide primary and preventive care and act as the member's advocate
- Initiate, supervise, and coordinate referrals for specialty care and inpatient services, maintaining continuity of member care, and including, as appropriate, transitioning young adult members from pediatric to adult providers

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

PCPs are responsible for rendering, or ensuring the provision of, covered preventive and primary care services for our members. These services will include, at a minimum, the treatment of routine illnesses, immunizations, health screening services, and maternity services, if applicable.

PCPs in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to members assigned to them, and attempt to verify the delivery of coordinated, quality care that is efficient and cost-effective. Coordination responsibilities include, but are not limited to:

- Referring members to behavioral health providers, providers, or hospitals within our network, as appropriate, and if necessary, referring members to out-of-network specialty providers
- Coordinating with our Prior Authorization department regarding prior authorization procedures for members
- Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers or hospitals
- Coordinating the medical care for the programs the member us assigned to, including at a minimum:
  - Oversight of drug regimens to prevent negative interactive effects
  - Follow-up for all emergency services
  - Coordination of inpatient care
  - Coordination of services provided on a referral basis
  - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.

PCPs are responsible for establishing and maintaining hospital admitting privileges that are sufficient to meet the needs of members or entering into formal arrangements for management of inpatient hospital admissions of members. This includes arranging for coverage during leave of absence periods with an in-network provider with admitting privileges.

PCP Contract Terminations
If you are a PCP and we terminate your contract for any of the following reasons, the member(s) 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
- Aetna Better Health of Maryland reduces your reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to Aetna Better Health of Maryland by the Department, and Aetna Better Health of Maryland and you are unable to negotiate a mutually acceptable rate.

Specialty Providers
Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. MDH requires Aetna Better Health of Maryland to maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits. If a PCP cannot locate an appropriate specialty provider, call Aetna Better Health of Maryland at **1-866-827-2710** for assistance. Specialists should provide services to members upon receipt of a written referral form from the member's PCP or from another Aetna Better Health of Maryland participating specialist. Specialists must coordinate with the PCP when members need a referral to another specialist. The specialist is responsible for verifying member eligibility prior to providing services.

When a specialist refers the member to a different specialist or provider, the original specialist must share these records with the appropriate provider or specialist. The sharing of the documentation should occur with no cost to the member, other specialists, or other providers.

Primary care providers (PCPs) should only refer members to Aetna Better Health of Maryland in-network specialists. If the member requires specialized care from a provider outside of our network, a prior authorization is required

Aetna Better Health of Maryland will maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits. If a specialty provider cannot be identified contact us at **1-866-827-2710** for assistance. If after calling Aetna Better Health of Maryland, you are unable to locate a specialist you may call the state's Provider Help Line at **1-800-766-8692**.

Specialty providers acting as PCPs
In limited situations, a member may select a physician specialist to serve as their PCP. In these instances, the specialist must be able to demonstrate the ability to provide comprehensive primary care. A specialist may be requested to serve as a PCP under the following conditions:

- When the member has a complex, chronic health condition that requires a specialist's care over a prolonged period of time and exceeds the capacity of the non-specialist PCP (i.e., members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex gelotology/oncology conditions, cystic fibrosis etc.)
- When a member's health condition is life threatening, or so degenerative, or disabling in nature to warrant a specialist serve in the PCP role.
- In unique situations where terminating the clinician-member relationship would leave the member without access to proper care or services or would end a therapeutic relationship that has been developed over time leaving the member vulnerable or at risk for not receiving proper care or services.

Aetna Better Health of Maryland's Chief Medical Officer (CMO) will coordinate efforts to review the request for a specialist to serve as PCP. The CMO will have the authority to make the final decision to grant PCP status, considering the conditions noted above.

Specialty providers acting as PCPs must comply with the appointment, telephone, and after-hours standards noted in Section 2. This includes arraigning for coverage 24 hours a day, 7 days a week.

Out of Network Providers and Single Case Agreements
When a member with a special need or requires services not able to be served through a contracted provider, Aetna Better Health of Maryland will authorize service through an out-of-network provider agreement. Our Medical Management team will arrange care by authorizing services to an out-of-network provider and facilitating transportation through the Maryland Department of Health's medical transportation program when there are no providers that can meet the member's special need available in a nearby location. If needed, our Network Development team will negotiate a Single Case Agreement (SCA) for the service and recruitment to join the provider network. The member may be transitioned to a network provider when the treatment or service has been completed or the member's condition is stable enough to allow a transfer of care.

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

Provider Requested Member Transfer
When persistent problems prevent an effective provider-patient relationship, a participating provider may ask an Aetna Better Health of Maryland member to leave their practice. Such requests cannot be based solely on the member filing a grievance, an appeal, a request for a Fair Hearing or other action by the patient related to coverage, high utilization of resources by the patient or any reason that is not permissible under applicable law.

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

- The provider must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:
  Aetna Better Health of Maryland
  10320 Little Patuxent Parkway, Suite 600
  Columbia, Maryland, 21044
- The provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care.
- Upon request, the provider will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

In the case of a PCP, Aetna Better Health of Maryland will work with the member to inform him/her on how to select another primary care practitioner.

Medical Records Requirements

Aetna Better Health of Maryland's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within the Aetna Better Health of Maryland provider network. Below is a list of Aetna Better Health of Maryland medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of the Aetna Better Health of Maryland Quality Management (QM) initiatives to maintain continuity and effective, quality patient care.

Provider records must be maintained in a legible, current, organized, and detailed manner that permits effective patient care and quality review. Providers must make records pertaining to Aetna Better Health of Maryland members immediately and completely available for review and copying by the department and federal officials at the provider's place of business, or forward copies of records to the department upon written request without charge.

Medical records must reflect the various aspects of patient care, including ancillary services. The member's medical record must be legible, organized in a consistent manner and must remain confidential and accessible to authorized persons only.

All medical records, where applicable and required by regulatory agencies, must be made available electronically.

All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements:

- Member identification information on each page of the medical record (i.e., name, Medicaid identification number)
- Documentation of identifying demographics including the member's name, address, telephone number, employer, Medicaid identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative
- Complying with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, but not limited to obtaining any required written member consents to disclose confidential medical records for complaint and appeal reviews
- Initial history for the member that includes family medical history, social history, operations, illnesses, accidents, and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member)
- Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries, and emergent/urgent care received
- Immunization records (recommended for adult members if available)
- Dental history if available, and current dental needs and services
- Current problem list (the record will contain a working diagnosis, as well as a final diagnosis and the elements of a history and physical examination, upon which the current diagnosis is based. In addition, significant illness, medical conditions, and health maintenance concerns are identified in the medical record.)

Patient visit data – Documentation of individual encounters must provide adequate evidence of, at a minimum:

- History and physical examination – Appropriate subjective and objective information is obtained for the presenting complaints.
- Plan of treatment.
- Diagnostic tests.
- Therapies and other prescribed regimens.
- Follow-up – Encounter forms or notes have a notation, when indicated, concerning follow-up care, call, or a visit. Specific time to return is noted in weeks, months, or as needed. Unresolved problems from previous visits are addressed in subsequent visits.
- Referrals, recommendations for specialty, behavioral health, dental and vision care, and results thereof.
- Other aspects of patient care, including ancillary services.
- Fiscal records – Providers will retain fiscal records relating to services they have rendered to members, regardless of whether the records have been produced manually or by computer.
- Recommendations for specialty care, behavioral health, dental and vision care and results thereof.
- Current medications (Therapies, medications, and other prescribed regimens – Drugs prescribed as part of the treatment, including quantities and dosages, will be entered into the record. If a prescription is telephoned to a pharmacist, the prescriber's record will have a notation to the effect)
- Documentation, initialed by the member's PCP, to signify review of:
  - Diagnostic information including:
    - Laboratory tests and screenings
    - Radiology reports
    - Physical examination notes
    - Other pertinent data
    - Reports from referrals, consultations, and specialists
    - Emergency/urgent care reports
- Hospital discharge summaries. Discharge summaries are included as part of the medical record for:
  - Hospital admissions that occur while the patient is enrolled in Aetna Better Health of Maryland
  - Prior admissions as necessary
  - Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed, and behavioral health history.
- Documentation as to whether an adult member has completed advance directives and location of the document (Maryland advance directives include living will, health care power of attorney, and mental health treatment declaration preferences and are written instructions relating to the provision of health care when the individual is incapacitated.)
- Documentation related to requests for release of information and subsequent releases, and
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.
- Entries – Entries will be signed and dated by the responsible licensed provider. The responsible licensed provider will countersign care rendered by ancillary personnel. Alterations of the record will be signed and dated.
- Provider identification – Entries are identified as to author.
- Legibility – Again, the record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

Medical record audits
Aetna Better Health of Maryland or CMS may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when we are responding to an inquiry on behalf of a member or provider, administrative responsibilities, or quality of care issues. Providers must respond to these requests promptly within 30 days of request. Medical records must be made available to the Maryland Department of Health for quality review upon request and free of charge.

Access to facilities and records
Providers are required to retain and make available all records pertaining to any aspect of services furnished to a member or their contract with Aetna Better Health of Maryland for inspection, evaluation, and audit for the longer of:

- A period of five years from the date of service
- Three years after final payment is made under the provider's agreement and all pending matters are closed.

Confidentiality and Accuracy of Member Records
Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies an Aetna Better Health of Maryland member. Original medical records must be released only in accordance with federal or Maryland laws, court orders, or subpoenas.

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

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

- The provider report must identify the disease or suspected disease and demographics on the member including the name age, race, sex and address of residence, hospitalization, date of death, etc. on a form provided by the Department (MDH1140) as directed by COMAR 10.06.01.
- With respect to patients with tuberculosis, you must:
  - Report each confirmed or suspected case of tuberculosis to the LHD within 48 hours.
  - Provide treatment in accordance with the goals, priorities, and procedures set forth in the most recent edition of the *Guidelines for Prevention and Treatment of Tuberculosis*, published by MDH.

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

Requirements include:

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

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

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

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

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

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

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. Aetna Better Health of Maryland expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, being sensitive to cultural diversity, and fostering respect for member's cultural backgrounds. Health Equity and Cultural Competency Training resources are available on our website at **www.aetnabetterhealth.com/maryland/providers/cultural-competency.html#resources_accordion**. Upon completion of the training, providers are required to complete our attestation form and return it to **ABHMDNetworkRelations@aetna.com**

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

In accordance with Title VI of the 1964 Civil Rights Act, national standards for culturally and linguistically appropriate health care services and state requirements, Aetna Better Health of Maryland is required to verify that Limited English Proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays, denials of services, receive care, services based on inaccurate or incomplete information. Providers must deliver services in a culturally effective manner to all members, including those with limited English proficiency (LEP) or reading skills.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay, or ability to speak English. Providers are required to treat all members with dignity and respect in accordance with federal law. Providers must deliver services in a culturally effective manner to all members, including:

- Those with limited English proficiency (LEP) or reading skills
- Those with diverse cultural and ethnic backgrounds
- The homeless
- Individuals with physical and mental disabilities

Interpreter services and auxiliary aids

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, Aetna Better Health makes its telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and provider. However, if the provider chooses to use another resource for interpretation services other than those provided by the Health Plan, the provider is financially responsible for associated costs.

Language interpretation services are available for use in the following scenarios:

- If a member requests interpretation services, Aetna Better Health Member Services.
- Representatives will assist the provider via a three-way call to communicate in the member's native language.
- For outgoing calls, Member Services dials the language interpretation service and uses an interactive voice response system to conference with a member and the interpreter.
- For face-to-face meetings, Aetna Better Health staff (e.g., Care Managers or Member Services) can conference in an interpreter to communicate with a member in his or her home or another location.
- When providers need interpreter services and cannot access them from their office, they can call

When providers need interpreter services and cannot access them from their office, they can call Aetna Better Health of Maryland to link with an interpreter.

Aetna Better Health of Maryland provides alternative methods of communication for members who are visually impaired, including large print and other formats. Contact our Member Services Department for alternative formats.

We strongly recommend the use of professional interpreters, rather than family or friends. Further, we provide member materials in other formats to meet specific member needs. Providers must also deliver information in a way the member understands.

Aetna Better Health of Maryland offers sign language and over the phone interpreter services at no cost to the provider or member. Please contact Aetna Better Health of Maryland at **1-866-827-2710** for more information on how to schedule these services in advance of an appointment.

Access for individuals with disabilities

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

Section VIII

QUALITY ASSURANCE MONITORING AND REPORTING FRAUD, WASTE, AND ABUSE

Quality Assurance Monitoring Plan

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

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

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

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

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

Fraud, Waste, and Abuse Activities
Aetna Better Health of Maryland has an aggressive and proactive fraud, waste, and abuse program that complies with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud, and external fraud. The Special Investigations Unit, (SIU), is a key element of the program. SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste or abuse to appropriate state and federal agencies as mandated by Maryland Administrative Code.

Aetna Better Health of Maryland uses a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Relations, Member Services, Medical Management, as well as providers and members, share the responsibility to detect and report fraud.

Special Investigation Unit (SIU)
The Special Investigation Unit (SIU) is well-staffed and highly trained. The SIU employs over 150 colleagues and has both investigative and prepay teams. Approximately one third of the Aetna SIU is dedicated to fraud investigations. SIU has a diverse team that includes: a medical director, nurses, certified coders, former law enforcement, pharmacy technicians, attorneys, accredited healthcare fraud investigators, certified fraud examiners, IT specialists, and administrative staff.

Reporting Suspected Fraud and Abuse
Participating providers are required to report to Aetna Better Health of Maryland all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

Providers can report suspected fraud, waste, or abuse by phone to our confidential Special Investigations Unit (SIU) hotline at **1-855-877-9735**. There are options for anonymous and confidential reporting. The SIU hotline is available 24 hours a day, 7 days a week.

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

A provider's best practice for preventing fraud, waste, and abuse, (also applies to laboratories as mandated by 42 C.F.R. 493), is to:

- Develop a compliance program
- Monitor claims for accuracy – verify coding reflects services provided
- Monitor medical records – verify documentation supports services rendered
- Perform regular internal audits
- Establish effective lines of communication with colleagues and members
- Ask about potential compliance issues in exit interviews
- Take action if you identify a problem

Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

Definitions of Fraud, Waste and Abuse

Fraud: Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal and/or state law. Examples include but are not limited to the following schemes:

- Billing for services that were never rendered,
- Misrepresenting who provided the services, altering claim forms, electronic claim records or medical documentation, and
- Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that aren't medically necessary.

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

- Performing large number of laboratory tests on patients when the standard of care indicates that only a few tests should have been performed on each of them,
- Medication and prescription refill errors, and
- Failure to implement standard industry waste prevention measures.

Abuse: Abuse includes actions that may, directly or indirectly, result in unnecessary costs to a health plan, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors. Examples include but are not limited to the following schemes:

- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered),
- Waiving patient co-pays or deductibles and over-billing, and
- Billing for items or services that should not be paid for by a health plan, such as never events.

In addition, member fraud is also reportable, and examples include:

- Falsifying identity, eligibility, or medical condition in order to illegally receive the drug benefit
- Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit
- Looping (i.e., arranging for a continuation of services under another members ID)
- Forging and altering prescriptions
- Doctor shopping (i.e., when a member consults a number of doctors for the purpose of obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.

Elements to a compliance plan

An effective compliance plan includes nine core elements:

1. Written Standards of Conduct: Development and distribution of written policies and procedures that promote Aetna Better Health of Maryland's commitment to compliance and that address specific areas of potential fraud, waste, and abuse.
2. Designation of a Compliance Officer: Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
3. Effective Compliance Training: Development and implementation of regular, effective education, and training.
4. Internal Monitoring and Auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
5. Disciplinary Mechanisms: Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in the Medicaid program.
6. Effective Lines of Communication: Between the Compliance Officer and the organization's employees, managers, and directors and members of the compliance committee, as well as related entities.
7. Includes a system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance, will maintaining confidentiality.
8. Related entities must report compliance concerns and suspected or actual misconduct involving Aetna Better Health of Maryland.
9. Procedures for responding to Detected Offenses and Corrective Action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.

Relevant laws

Aetna is committed to complying with all applicable federal and state laws, regulations and other requirements pertaining to FWA. Aetna will not tolerate health care FWA in any of its relationships with internal and external parties. Aetna will identify, report, monitor, and when appropriate, refer for prosecution, situations in which suspected fraud or abuse occurs. Providers contracted with Aetna Better Health of Maryland must agree to be bound by and comply with all applicable Maryland and federal laws and regulations.

There are numerous laws and regulations, both federal and state, that address health care fraud. These laws define fraud and establish the framework for prosecuting criminal acts and the initiation of civil proceedings. Some of those laws are described below:

Federal False Claims Act – (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims.

Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:

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

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items of services reimbursable by a federal health care program. Remuneration includes anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

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

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

Health Information Portability and Accountability ("HIPAA") requires:

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

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

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

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

Under the Maryland False Claims Act, Md. Code Ann., Health General §2-601 et. seq.

Administrative sanctions can be imposed, as follows:

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

Remediation may include any or all of the following:

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

Exclusion lists & death master report

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

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

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

ATTACHMENTS

ATTACHMENT 1

Rare and Expensive Case Management (REM) Program

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

Medicaid services and benefits

To qualify for the REM program, a member must have one or more of the diagnoses specified in the Rare and Expensive Disease List below. The members may elect to enroll in the REM Program, or to remain in Aetna Better Health of Maryland if the Department agrees that it is medically appropriate. REM participants are eligible for fee-for-service benefits currently offered to Medicaid-eligible participants not enrolled in MCOs as well as additional, optional services, which are described in COMAR 10.09.69.

The participant's REM case manager will:

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

Referral and enrollment process

Candidates for REM are generally referred from HealthChoice MCOs, providers, or other community sources. Self-referral or family-referral is also acceptable. Referral must include a physician's signature and the required supporting documentation for the qualifying diagnosis(es). A registered nurse reviews the medical information: in order to determine the member's eligibility for REM. If the Intake nurse determines that there is no qualifying REM diagnosis, the application is sent to the REM physician advisor for a second level review before a denial notice is sent to the member and referral source. If the member does not meet the REM criteria, they will remain enrolled in the MCO.

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

For questions and referral forms call **1-800-565-8190**; fax forms to **410-333-5426** or mail to:

REM Intake Unit
Maryland Department of Health
201 W. Preston Street, Room 210
Baltimore, MD 21201-2399

Table of Rare and Expensive Diagnosis

ICD10	ICD 10 Description	AGE LIMIT
B20	Human immunodeficiency virus (HIV) disease	0-20
C96.0	Multifocal and multisystemic Langerhans-cell histiocytosis	0-64
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis	0-64
C96.6	Unifocal Langerhans-cell histiocytosis	0-64
D61.01	Constitutional (pure) red blood cell aplasia	0-20
D61.09	Other constitutional aplastic anemia	0-20
D66	Hereditary factor VIII deficiency	0-64
D67	Hereditary factor IX deficiency	0-64
D68.0	Von Willebrand's disease	0-64
D68.1	Hereditary factor XI deficiency	0-64
D68.2	Hereditary deficiency of other clotting factors	0-64
E70.0	Classical phenylketonuria	0-20
E70.1	Other hyperphenylalaninemias	0-20
E70.20	Disorder of tyrosine metabolism, unspecified	0-20
E70.21	Tyrosinemia	0-20
E70.29	Other disorders of tyrosine metabolism	0-20
E70.30	Albinism, unspecified	0-20
E70.40	Disorders of histidine metabolism, unspecified	0-20
E70.41	Histidinemia	0-20
E70.49	Other disorders of histidine metabolism	0-20
E70.5	Disorders of tryptophan metabolism	0-20
E70.8	Other disorders of aromatic amino-acid metabolism	0-20
E71.0	Maple-syrup-urine disease	0-20
E71.110	Isovaleric acidemia	0-20
E71.111	3-methylglutaconic aciduria	0-20
E71.118	Other branched-chain organic acidurias	0-20
E71.120	Methylmalonic acidemia	0-20
E71.121	Propionic acidemia	0-20
E71.128	Other disorders of propionate metabolism	0-20
E71.19	Other disorders of branched-chain amino-acid metabolism	0-20
E71.2	Disorder of branched-chain amino-acid metabolism, unspecified	0-20
E71.310	Long chain/very long chain acyl CoA dehydrogenase deficiency	0-64
E71.311	Medium chain acyl CoA dehydrogenase deficiency	0-64
E71.312	Short chain acyl CoA dehydrogenase deficiency	0-64
E71.313	Glutaric aciduria type II	0-64
E71.314	Muscle carnitine palmitoyltransferase deficiency	0-64
E71.318	Other disorders of fatty-acid oxidation	0-64
E71.32	Disorders of ketone metabolism	0-64
E71.39	Other disorders of fatty-acid metabolism	0-64
E71.41	Primary carnitine deficiency	0-64
E71.42	Carnitine deficiency due to inborn errors of metabolism	0-64
E71.50	Peroxisomal disorder, unspecified	0-64
E71.510	Zellweger syndrome	0-64
E71.511	Neonatal adrenoleukodystrophy	0-64
E71.518	Other disorders of peroxisome biogenesis	0-64

E71.520	Childhood cerebral X-linked adrenoleukodystrophy	0-64
E71.521	Adolescent X-linked adrenoleukodystrophy	0-64
E71.522	Adrenomyeloneuropathy	0-64
E71.528	Other X-linked adrenoleukodystrophy	0-64
E71.529	X-linked adrenoleukodystrophy, unspecified type	0-64
E71.53	Other group 2 peroxisomal disorders	0-64
E71.540	Rhizomelic chondrodysplasia punctata	0-64
E71.541	Zellweger-like syndrome	0-64
E71.542	Other group 3 peroxisomal disorders	0-64
E71.548	Other peroxisomal disorders	0-64
E72.01	Cystinuria	0-20
E72.02	Hartnup's disease	0-20
E72.03	Lowe's syndrome	0-20
E72.04	Cystinosis	0-20
E72.09	Other disorders of amino-acid transport	0-20
E72.11	Homocystinuria	0-20
E72.12	Methylenetetrahydrofolate reductase deficiency	0-20
E72.19	Other disorders of sulfur-bearing amino-acid metabolism	0-20
E72.20	Disorder of urea cycle metabolism, unspecified	0-20
E72.21	Argininemia	0-20
E72.22	Arginosuccinic aciduria	0-20
E72.23	Citrullinemia	0-20
E72.29	Other disorders of urea cycle metabolism	0-20
E72.3	Disorders of lysine and hydroxylysine metabolism	0-20
E72.4	Disorders of ornithine metabolism	0-20
E72.51	Non-ketotic hyperglycinemia	0-20
E72.52	Trimethylaminuria	0-20
E72.53	Primary Hyperoxaluria	0-20
E72.59	Other disorders of glycine metabolism	0-20
E72.81	Disorders of gamma aminobutyric acid metabolism	0-20
E72.89	Other specified disorders of amino-acid metabolism	0-20
E74.00	Glycogen storage disease, unspecified	0-20
E74.01	von Gierke disease	0-20
E74.02	Pompe disease	0-20
E74.03	Cori disease	0-20
E74.04	McArdle disease	0-20
E74.09	Other glycogen storage disease	0-20
E74.12	Hereditary fructose intolerance	0-20
E74.19	Other disorders of fructose metabolism	0-20
E74.21	Galactosemia	0-20
E74.29	Other disorders of galactose metabolism	0-20
E74.4	Disorders of pyruvate metabolism and gluconeogenesis	0-20
E75.00	GM2 gangliosidosis, unspecified	0-20
E75.01	Sandhoff disease	0-20
E75.02	Tay-Sachs disease	0-20
E75.09	Other GM2 gangliosidosis	0-20
E75.10	Unspecified gangliosidosis	0-20

E75.11	Mucolipidosis IV	0-20
E75.19	Other gangliosidosis	0-20
E75.21	Fabry (-Anderson) disease	0-20
E75.22	Gaucher disease	0-20
E75.23	Krabbe disease	0-20
E75.240	Niemann-Pick disease type A	0-20
E75.241	Niemann-Pick disease type B	0-20
E75.242	Niemann-Pick disease type C	0-20
E75.243	Niemann-Pick disease type D	0-20
E75.248	Other Niemann-Pick disease	0-20
E75.25	Metachromatic leukodystrophy	0-20
E75.26	Sulfatase deficiency	0-20
E75.29	Other sphingolipidosis	0-20
E75.3	Sphingolipidosis, unspecified	0-20
E75.4	Neuronal ceroid lipofuscinosis	0-20
E75.5	Other lipid storage disorders	0-20
E76.01	Hurler's syndrome	0-64
E76.02	Hurler-Scheie syndrome	0-64
E76.03	Scheie's syndrome	0-64
E76.1	Mucopolysaccharidosis, type II	0-64
E76.210	Morquio A mucopolysaccharidoses	0-64
E76.211	Morquio B mucopolysaccharidoses	0-64
E76.219	Morquio mucopolysaccharidoses, unspecified	0-64
E76.22	Sanfilippo mucopolysaccharidoses	0-64
E76.29	Other mucopolysaccharidoses	0-64
E76.3	Mucopolysaccharidosis, unspecified	0-64
E76.8	Other disorders of glucosaminoglycan metabolism	0-64
E77.0	Defects in post-translational mod of lysosomal enzymes	0-20
E77.1	Defects in glycoprotein degradation	0-20
E77.8	Other disorders of glycoprotein metabolism	0-20
E79.1	Lesch-Nyhan syndrome	0-64
E79.2	Myoadenylate deaminase deficiency	0-64
E79.8	Other disorders of purine and pyrimidine metabolism	0-64
E79.9	Disorder of purine and pyrimidine metabolism, unspecified	0-64
E80.3	Defects of catalase and peroxidase	0-64
E84.0	Cystic fibrosis with pulmonary manifestations	0-64
E84.11	Meconium ileus in cystic fibrosis	0-64
E84.19	Cystic fibrosis with other intestinal manifestations	0-64
E84.8	Cystic fibrosis with other manifestations	0-64
E84.9	Cystic fibrosis, unspecified	0-64
E88.40	Mitochondrial metabolism disorder, unspecified	0-64
E88.41	MELAS syndrome	0-64
E88.42	MERRF syndrome	0-64
E88.49	Other mitochondrial metabolism disorders	0-64
E88.89	Other specified metabolic disorders	0-64
F84.2	Rett's syndrome	0-20
G11.0	Congenital nonprogressive ataxia	0-20

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

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

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

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

ATTACHMENT 2

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

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

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

Age: **Chief Complaint:**
HPI:

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

Physical Findings:

General: ☐ Alert/NAD
☐ Pertinent:

Head: ☐ Normal
☐ Pertinent:

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

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

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

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

Neck: ☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: ☐ No lymphadenopathy
☐ Pertinent:

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

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

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

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

Extremities: ☐ FROM
☐ Pertinent:

Neurologic: ☐ Grossly intact
☐ Pertinent:

Skin: ☐ Intact, no rashes
☐ Pertinent:

ASSESSMENT: **PLAN:**

Rx Ordered:

Labs Ordered:

Radiology Services Ordered:

PCP F/U Required:
☐ **Yes** ☐ **No**

Provider Signature: _____

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

ATTACHMENT 3

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	www.alleganyhealthdept.com/
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	www.aahealth.org/
Baltimore City	410-396-4398	410-396-7633	410-649-0521	health.baltimorecity.gov/
Baltimore County	410-887-2243	410-887-2828	410-887-4381	www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	www.calverthealth.org/
Caroline	410-479-8000	410-479-8014	410-479-8189	MDH.maryland.gov/carolinecounty
Carroll	410-876-2152	410-876-4813	410-876-4941	cchd.maryland.gov/
Cecil	410-996-5550	410-996-5171	410-996-5130	www.cecilcountyhealth.org
Charles	301-609-6900	301-609-6923	301-609-6760	www.charlescountyhealth.org/
Dorchester	410-228-3223	410-901-2426	410-901-8167	www.dorchesterhealth.org/
Frederick	301-600-1029	301-600-3124	301-600-3124	health.frederickcountymd.gov/
Garrett	301-334-7777	301-334-7727	301-334-7771	garretthealth.org/
Harford	410-838-1500	410-638-1671	410-942-7999	harfordcountyhealth.com/
Howard	410-313-6300	877-312-6571	410-313-7323	www.howardcountymd.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	kenthd.org/
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1635	www.montgomerycountymd.gov/hhs/
Prince George's	301-883-7879	301-856-9555	301-856-9550	www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4456	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-4330	www.smchd.org/
Somerset	443-523-1700	443-523-1722	443-523-1758	somersethealth.org/
Talbot	410-819-5600	410-819-5609	410-819-5600	talbothealth.org
Washington	240-313-3200	240-313-3264	240-313-3229	MDH.maryland.gov/washhealth
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	www.wicomicohealth.org/
Worcester	410-632-1100	410-632-0092	410-629-0614	www.worcesterhealth.org/

ATTACHMENT 4

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

HealthChoice
LOCAL HEALTH SERVICES REQUEST FORM

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

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

Contact Person: Contact Phone:	☐ Contact Complete: Date: / / ☐ Unable to Locate: Date: / / ☐ Referred to: Date: / /
Comments:	

MDH 4582 8/14

ATTACHMENT 5

Maryland

DEPARTMENT OF HEALTH

Maryland Prenatal Risk Assessment- MDH 4850 (02/2022)

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

Provider Demographic Information:

Date of Initial Prenatal Visit/ Form Completed: __/_____/_____

Provider NPI#: ____ Site NPI#_____ Provider Name: _____Provider Phone Number: ___-_____-_____

Patient Demographic Information:

Patient Last Name:_____First Name:_____ Middle I:_ DOB: ___/_____/_____ Preferred Pronouns: _____

Social Security Number: ____-_____-_____ Medical Assistance Number (MA): ____

Current Address: Street _____County __State____ZipCode _

Best Contact Phone Number: _____-_____-_____ Email: ___

Emergency Contact Name: _____ Contact Phone Number:____-_____-_____ Communication Barrier: Yes _____(Requires an Interpreter Y/N) No _____ Primary Language _____

Insurance Status (at time of prenatal visit):

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

Demographics:

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

Obstetric History Gravida___Para____:

#Full Term Births		#Preterm Births		#Ectopic Pregnancies	
#Spontanous Abortions		#Theraputic Abortions		#Living Children	

Entry to Prenatal Care:

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

Risk Factor Assessment:

Psychosocial Risks (Check all that apply)

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

Medical Risks (Check all that apply)

Maternal Age	Age< or = 16 Age> or = 35
Maternal BMI	BMI<18.5 or BMI>30
Sexually Transmitted Infection – STI. (GC/Chlamydia/HIV/Hep B/C or Syphilis)	Current/Recently Treated STI: STI Name: STI screening (including Syphilis) completed for current Pregnancy: Y N Past STI Hx: (Syphilis) (Herpes
Dental Care	Last Dental visit >1 year. Y N

Pregnancy Risk Factors (Check all that apply)

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

DEFINITIONS (To help complete Risk Assessment)

[1]Mental/Behavioral Health	Concern for the need of BH Services.
[1]Intimate Partner/Family Violence/Abuse	Physical, psychological abuse or violence within the patient's environment.
[1]Exposure to long-term stress	Partner-related, financial, personal, emotional.
[2]Substance Misuse	• Concern for use of illegal substances within the past 6 months. • At "risk-drinker" as determined by a screening tool such as T-ACE, CAGE, or AUDIT.
[3]Financial Insecurity	Example: Unemployed > 3months. Involved in exchanging sex for drugs.
[4]Lack of social/emotional support	Absence of support system I.e. family/friends. Feeling isolated.
Family History/Genetic risk.	At risk for a genetic or hereditary disorder. Known genetic carrier. H/O congenital anomalies.
Communication barrier	In need of an interpreter.
Dental Care	Last Dental Visit > 1year.
Prior Preterm birth	H/O of preterm birth (prior to the 37th gestational age).
Prior LBW birth	Low birth weight birth (under 2,500

Chronic Disease	Asthma: Y N Inhaler Rx: Y N Diabetes Y N If YES then Treatment Medication: _ Chronic HTN/Heart Disease: Y N Sickle Cell Disease: Y N Sickle Cell Trait: Y N Anemia – HCT<33 or HGB <11: Y No Lab Result _____ AutoImmune Disorder: Y N If yes please name: _____ H/O – Thrombophilias/DVT: If yes please describe. _____

Maryland Prenatal Risk Assessment Form (Instructions for use)

Purpose of Form: Identifies pregnant women who may benefit from local health department Administrative Care Coordination (ACCU) services and serves as the referral mechanism. ACCU services complement medical care and may be provided by nurses, community health and outreach workers and may include education about Medicaid benefits, reinforcement of the medical plan of care, resource linkage and other related services.
.
Instructions: On the initial visit the provider/staff will complete the demographic and assessment sections for pregnant women enrolled in Medicaid at registration and those applying for Medicaid.

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

Faxing and Handling Instructions: Do not fold, bend, punch holes or staple forms. **Fax the MPRA to the local health department in the client's county of residence**. To reorder forms call the local ACCU.

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

Mailing Address (client resides)	**Phone Number**
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-55107 Fax: 301-777-2401
Anne Arundel County ACCU 3 Harry S. Truman Parkway, HD8 Annapolis, MD 21401	410-222-7177 Fax: 410-222-4150
Baltimore City ACCU Healthcare Access Maryland 1 N. Charles St., #900 Baltimore, MD 21201	410-410-949-2357 Fax: 1-888-657-8712
Baltimore County ACCU 6401 Yo rk Rd., 3rd Floor Baltimore, MD 21212	410-887- 4381 Fax: 410-828-8346
Calvert County ACCU 975 N. Solomon's Island Rd, Prince Frederick, MD 20678	410-535-5400 Fax: 410-535-1955
Caroline County ACCU 403 S. 7th St. Denton, MD 21629	410-479-8189 Fax: 410-479-4871
Carroll County ACCU 290 S. Center St, Westminster, MD 21158-0845	410-876-4941 Fax: 410-876-4949
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5130 Fax: 410-996-0072
Charles County ACCU 4545 Crain Highway White Plains, MD 20695	301-609-6760 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-901-8167Fax: 410-228-8976
Frederick County ACCU 350 Montevue Lane Frederick, MD 21702	301-600-3131 Fax: 301-600-3372
Garrett County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7695 Fax: 301-334-7771
Harford County ACCU 2015 Pulaski Highway, #E, Havre De Grace, MD 21078	410-942-7909 Fax: 443-502-8975
Howard County ACCU 8930 Stanford Blvd., . Columbia, MD 21045	410-313-7567 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7035 Fax: 410-778-7019
Montgomery County ACCU 1401 Rockville Pike, #2400 Rockville, MD 20852	240-777-1648 Fax: 240-777-1604
Prince George's County ACCU 9314 Piscataway 'Rd., Clinton, MD 20735	301-301-856-9403Fax: 301-856-9628
Queen Anne's County ACCU 206 N. Commerce Street Centreville, MD 21617	443-262-4456 Fax: 443-262-9357
St Mary's County ACCU 21580 Peabody St. Leonardtown, MD 20650	301-475-6776 Fax: 301-309-4117
Somerset County ACCU 8928 Sign Post Rd., Westover, MD 21871	443-523-1758 Fax: 410-651-2572
Talbot County ACCU 100 S. Hanson Street Easton, MD 21601	410-819-5600 Fax: 410-819-5683
Washington County ACCU 1302 Pennsylvania Avenue Hagerstown, MD 21742	240-313-3464 Fax: 240-313-3222
Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6987

ATTACHMENT 6

Maryland
DEPARTMENT OF HEALTH

Enriched Maternity Services Record (02/2022)

Name:___ MA#: ___

Date Risk Assessment Completed: ___

Phase of Pregnancy	**Counseling Topic**	**Date & Initials of Provider**					
Prenatal Care	Benefits of regular Prenatal Visits						
	Reviewed Antenatal Screening options						
	Maternal Obesity – Nutrition						
	Healthy LifeStyle – Anxiety/Stress Management & Exercise in Pregnancy						
	Performed Depression Screening						
	Immunizations (Influenza & Covid 19)						
	Risks of ETOH/Tobacco Use Risks of Illegal substance/Opioid Use. MOM Resources						
	Benefits of Preventive Dental Care						
	Preterm Labor Education						
	Screened for Intimate Partner/Family – Abuse/Violence.						
	Discussed Behavioral Health Resources						
	Discussed Social Support Services (Housing/Transportation/Language Barriers)						
	Discussed Doula & Childbirth Education						
Postpartum Care	Benefits of WIC – Resources Breastfeeding (Benefits/Support)						
	Discussed Infant Car Seat Requirements						
	Discussed establishing Pediatric Care						
	Importance of Postpartum Care/followup						
	Safe Haven https://dhs.maryland.gov/safe-haven/						
	Postpartum Depression Screening (Example: Edinburgh or Beck Screens.)						
	Reviewed Family Planning options						

For assistance with care coordination and referral to support services – i.e. WIC, substance use or mental health treatment, community resources, contact the LHD ACCU (see contact info on back of MPRA) Date referred_____

ATTACHMENT 6

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

Mailing Address	Phone Number
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-5094 Fax: 301-777-2401
Anne Arundel County ACCU 1 Harry S. Truman Parkway, Ste 200 Annapolis, MD 21401	410-222-7541 Fax: 410-222-4150
Baltimore City ACCU HealthCare Access Maryland 201 E. Baltimore St, Ste. 1000 Baltimore, MD 21202	410-649-0526 Fax: 1-888-657-8712
Baltimore County ACCU 6401 York Rd., 3rd Floor Baltimore, MD 21212	410-887- 4381 Fax: 410-828-8346
Calvert County ACCU 975 N. Solomon's Island Rd, P.O. Box 980 Prince Frederick, MD 20678	410-535-5400 Fax: 410-535-1955
Caroline County ACCU 403 S. 7th St., P.O. Box 10 Denton, MD 21629	410-479-8023 Fax: 410-479-4871
Carroll County ACCU 290 S. Center St, P. O. Box 845 Westminster, MD 21158-0845	410-876-4940 Fax: 410-876-4959
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5145 Fax: 410-996-0072
Charles County ACCU 4545 Crain Highway, P.O. Box 1050 White Plains, MD 20695	301-609-6803 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-228-3223 Fax: 410-228-8976
Frederick County ACCU 350 Montevue Lane Frederick, MD 21702	301-600-3341 Fax: 301-600-3302

Garrett County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7692 Fax: 301-334-7771
Harford County ACCU 34 N. Philadelphia Blvd. Aberdeen, MD 21001	410-273-5626 Fax: 410-272-5467
Howard County ACCU 7180 Columbia Gateway Dr. Columbia, MD 21044	410-313-7323 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7039 Fax: 410-778-7019
Montgomery County ACCU 1335 Piccard Drive, 2nd Floor Rockville, MD 20850	240-777-1635 Fax: 240-777-4645
Prince George's County ACCU 9201 Basil Court, Room 403 Largo, MD 20774	301-883-7231 Fax: 301-856-9607
Queen Anne's County ACCU 206 N. Commerce Street Centreville, MD 21617	443-262-4481 Fax: 443-262-9357
St Mary's County ACCU 21580 Peabody St., P.O. Box 316 Leonardtown, MD 20650-0316	301-475-4951 Fax: 301-475-4350
Somerset County ACCU 7920 Crisfield Highway Westover, MD 21871	443-523-1740 Fax: 410-651-2572
Talbot County ACCU 100 S. Hanson Street Easton, MD 21601	410-819-5600 Fax: 410-819-5683
Washington County ACCU 1302 Pennsylvania Avenue Hagerstown, MD 21742	240-313-3229 Fax: 240-313-3222
Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6568
Worcester County ACCU 9730 Healthway Dr. Berlin, MD 21811	410-629-0164 Fax: 410-629-0185

ATTACHMENT 7

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

Attachment 8

Edifecs CRA

Aetna Better Health is working with Edifecs to enable "CRA", a solution designed to alert providers when diagnosis codes are potentially missing from a claim. This is accomplished by sending the biller the standard EDI response files (277CA) associated with claim status that are integrated into the claim submission process. The automated messages appear in the billing solution rejection notification queue and are triggered on claims that may be incomplete or inaccurate for patients with historic claims data, such as evidence of an established diagnosis of a chronic condition that is not present on the current claim.

Program Benefits:

Edifecs CRA – Capture diagnosis codes to accurately capture a member's chronic conditions and deliver complete and accurate claims the first time.

As the healthcare industry faces unprecedented change, Aetna Better Health is focused on helping its members receive the specific care they need at the time they need it. It is also focused on helping providers ensure that the care they provide to the plan's members is completely, accurately, and efficiently reported and submitted within the provider's existing submission workflow.

For the member, the CRA solution enhances the medical provider's awareness of their potential medical conditions, thereby increasing the opportunity or need to receive the right level of care and services or follow-up care and services from their medical health plan and its provider network.

For the provider, the CRA solution brings another opportunity for awareness of their patient's medical history and ensures a line of sight to the accuracy of their billing practices within the medical office. The solution may also reduce some of the administrative rework associated with the existing health plan's chart review process that frequently occurs to maximize health plan quality standards and measures. The CRA solution fosters improved accuracy and agreement between the patient's medical record and the claim submission. CRA does not create an administrative burden because it targets only the claims where the rendering provider's specialty relates to chronic medical conditions in the member's medical history. At the rendering provider level, CRA sends an average of less than 3 claim alerts per month. Responses to the alerts by the biller will be received by Aetna Better Health within one business day, so there is very little impact to the providers.

Sample Alert Message (277CA):

The following is an example of a CRA notification you will receive in the Practice Management System's rejection notification queue when there is a suspected diagnosis coding omission, presenting up to five diagnosis codes**:**

> Patient history includes ICD: [ICD-10 Code History Here]; review the medical record for DOS, validate claim Dx codes are complete and accurate; resend claim. Questions, visit https://help.edifecsfedcloud.com/CRAEducationCenter/Content/Home.htm

If Your Office Receives a CRA Messaging via (277CA):

Once CRA is enabled, your office may receive this message for those members with evidence of an existing diagnosis of a chronic condition within medical history. At that time, you should take the following actions:

- **Engage a qualified coder** or appropriate professional to review the patient's medical record to confirm that the diagnosis(es) coded on the claim are complete and accurate.
- If the coding on the **claim is complete** as-is, resubmit the claim for clearinghouse processing maintaining the using the original patient control number (CLM01/CMS-1500 Box26).
- If **changes are necessary**, make the changes where appropriate and resubmit the claim maintaining the original patient control number (CLM01/CMS-1500 Box26).
- If a **diagnosis is added to** or **removed from** the claim, billers should ensure that the medical record for the date of service completely supports the revised claim. Also ensure that all affected claim fields are aligned appropriately (i.e., order of the diagnoses reported, Diagnosis Pointers), being careful to consider claim form and ICD-10 Coding Guidelines.

Provider Resources and Options:

Please visit https://help.edifecsfedcloud.com/CRAEducationCenter/Content/Home.htm to review the support materials, which includes a Question and Answer resource.

Please email CRA_AETNA@EDIFECS.COM if your preference is to not participate in the solution. Please include your:

- Rendering NPI
- Rendering Provider Name
- Billing NPI
- Billing Provider Name
- Contact Name
- Contact email or phone number

For **questions about a claim status message**, visit www.AetnaBetterHealth.com and select your state to be guided to your state specific Provider Services Call Center.