PROVIDER MANUAL

District of Columbia Healthy Families
And
DC Healthcare Alliance

July 2014
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Section I
GENERAL INFORMATION
A. Welcome to MedStar Family Choice

MedStar Family Choice (MSFC) is a Managed Care Organization contracted by the District of Columbia Health Care Finance to provide services to members enrolled in the DC Healthy Families and DC Healthcare Alliance programs. MSFC is a subsidiary of MedStar Health, a large not-for-profit, regional healthcare system that has a network of ten hospitals and more than 20 other health-related businesses across the Washington D.C. and Maryland region. As the area’s largest health system, it is one of the region's largest employers with more than 27,000 associates and 5,600 affiliated physicians.

We are dedicated to building the type of integrated system necessary to deliver effective, high quality health care to all DC Medicaid eligible populations enrolled in the District of Columbia Health Families Program (DHFP) and DC Health Care Alliance program. MSFC believes that by offering physicians the appropriate managerial and systems support MSFC will be able to help them do what they do best-practice medicine.

B. DC HEALTHY FAMILIES AND DC HEALTHCARE ALLIANCE PROGRAMS

As noted above, MedStar Family Choice has contracted with the District of Columbia Health Care Finance to provide covered services to eligible individuals enrolled in both the DC Healthy Families and DC Healthcare Alliance programs. This manual discusses both products. The policies and procedures in this manual apply to both products, unless specifically noted. Authorization policies are listed in Chapter 3 and the differences are listed by product. The specific covered services provided under each product are described in Chapter 4. Providers should note specifically, the following differences:

- Vision (no Alliance coverage)
- Transportation (in network emergency only for Alliance)
- Pharmacy benefits (must use the DC Pharmacy Provider Network pharmacies)
- Deliveries (not covered under Alliance)
- Behavioral Health (not covered under Alliance)
- Emergency services (not covered by MSFC for Alliance)
- Open Heart surgery and organ transplants (not covered under Alliance)
- Dialysis
- Services outside of the District of Columbia (not covered under Alliance)

Additional differences in the programs are outlined in Chapter 4 of this manual.

If you have any questions about MedStar Family Choice, or the information contained in this manual, please do not hesitate to contact Provider Relations at (855) 210-6203.
C. MEDSTAR FAMILY CHOICE WEBSITE

Members and providers can access the MedStar Family Choice website at www.medstarfamilychoice.com. There is a separate section of the website for the DC Healthy Families and DC Healthcare Alliance programs. The website will provide you with information related to the following:

- Appeal process
- Availability of UM criteria and UM policies
- Case management and disease management services
- Claims information (including link to online claims status check)
- Clinical practice guidelines and preventive services guidelines for adults and children
- Contact information for our company
- Credentialing process
- Find-A-Provider (searchable provider directory), including ancillary providers
- Formulary and pharmacy updates
- Fraud and Abuse information
- Hours of operation and after-hours instructions
- Interpreter services
- Medical record documentation guidelines and policies
- Member rights and responsibilities
- Notice of privacy practices
- Outreach program
- Pharmacy protocols and procedures
- Pre-authorization requirements
- Provider manual
- Provider Newsletters
- Quality improvement programs
- Quick reference guide
- Schedule of health education classes
- Transportation guidelines
- Utilization management decision making

If your office does not have access to the internet, all of these materials are available in print by contacting our Provider Relations Department, Monday-Friday, 8:00-5:30 p.m. at (855) 210-6203.
D. MEMBER RIGHTS AND RESPONSIBILITIES

**MSFC Medicaid and Alliance members have the right to:**

- Be treated with respect and dignity not matter race, color, creed, ancestry, marital status, political affiliation, national origin, age, sexual orientation, religion, gender, personal appearance, physical or mental disability, or type of illness or condition.
- Have access to care no matter race, color, creed, ancestry, marital status, political affiliation, national origin age, sexual orientation, religion, gender, personal appearance, physical or mental disability or type of illness or condition.
- Privacy - medical records and all information about the member’s health is private and will only be shared in a manner that follows District and federal laws.
- Privacy during treatment.
- Information - members may ask for and receive information about MedStar Family Choice, its services, its doctors and other caregivers, and about their rights and responsibilities as a member of the health plan.
- Make recommendations regarding their rights and responsibilities as a member of MedStar Family Choice.
- Ask for qualifications of the people treating them.
- Choose a primary care provider (PCP) from MedStar Family Choice’s listing of doctors and to change their PCP. Be told what their health problem is, what treatment they will be given and what risks are related to their illness and treatment. This must be told to them so that they understand the information.
- Talk to their doctor and help to make choices and decision about their healthcare and treatments.
- Choose someone who will have the legal rights to make healthcare choices for them if they become unable to tell their own wishes.
- Refuse any treatment by a provider, and be told what might happen if they don't have the treatment.
- Discuss all of the appropriate or medically necessary treatment options, regardless of the cost or whether they are covered by their health plan. MedStar Family Choice does not restrict providers from discussing all of the appropriate or medically necessary treatment options with members.
- Receive Family Planning Services and supplies from the provider of their choice. (Alliance members must remain in network.)
- Obtain medical care without unnecessary delay.
- Receive information on Advanced Directives or a Living Will, develop Advanced Directives or a Living Will and choose not to have or continue any life-sustaining treatment.
- Continue treatment they are currently receiving until they have a new treatment plan.
- Receive interpretation and translation Services free of charge if they need them.
- Refuse oral interpretation services.
• Get an explanation of prior authorization procedures
• Be free from any form or 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.
• Exercise their rights and know that the exercise of those rights will not adversely affect the way that MedStar Family Choice or our providers treat them.
• File a complaint, appeal or grievance with MedStar Family Choice and have it resolved in a reasonable amount of time. For example, the complaint, appeal or grievance could include a concern about the care they received.
• Request an appeal or Fair Hearing if they feel MSFC was wrong in denying, reducing, or stopping a service or item.
• Request that ongoing benefits be continued during an appeal or fair hearing.
• Receive a second opinion from another doctor in MedStar Family Choice if they don’t agree with their doctor’s opinion about the services that they need.
• Receive a copy of the MedStar Family Choice member handbook.
• Obtain summaries of customer satisfaction surveys.
• Receive MedStar Family Choice’s “Dispense As Written” policy for prescription drugs
• Receive other information about MSFC, such as how MSFC is managed, our financial condition and any special ways MSFC pays our providers. Members may request this information by calling 1-888-404-3549.
• Receive a copy of MSFC practice guidelines upon request. Members may request this information by calling 1-888-404-3549.

MSFC Members have the responsibility to:
• Read the member handbook so that they can understand the services provided and how to contact MedStar Family Choice with questions.
• Be courteous and respectful to MedStar Family Choice staff, healthcare providers and office staff.
• Tell the truth about their health. They must tell about any illnesses they had before. They must tell about operations they had before. They must tell what medicines they use or have used in the past. Members must tell MSFC and their healthcare providers any information they may need in order to provide care to the members.
• Do what their doctor tell them to do to get well or stay well. Follow the plans and instructions for their care that they and their health care provider have agreed to.
• Live a healthy lifestyle, which includes seeing their doctor regularly and following preventive care guidelines, such as screening and immunizations.
• Accept what might happen to them if they refuse treatment or if they do not follow the advice given to them.
• Tell their doctor if their health changes in any way that they did not expect.
• Know the name of their primary care provider (PCP) and get their PCP’s okay before
getting care from anyone else.

- Make appointments with their PCP during office hours instead of using the emergency room for things that are not emergencies. The emergency room should only be used when they have a medical emergency.
- Be on time for all their appointments. Let the office know at least 24 hours ahead of time when they cannot keep an appointment.
- Help their doctor get medical records from providers who have treated them in the past.
- Follow the rules of the D.C. Medicaid Managed Care Program
- Carry their ID card and photo ID with them always. Tell the people in the doctor’s office, lab, drugstore or anywhere that they are getting healthcare, that they are MSFC member.
- Ask questions about their care. Make sure that they understand what their health problem is, that they understand their treatment and that they participate in developing treatment goals that both the provider and the member agree on.
- Notify MedStar Family Choice of any car accidents, falls, etc where someone else may be at fault.
- Complete the renewal applications in a timely manner to prevent gaps in their health insurance.
- Report any other health insurance coverage to Economic Security Administration at 202-727-5355.
- Give the doctor a copy of their Living Will and Advanced Directive if they have one.
- Report any known or suspected fraud and abuse as it relates to benefits, services or payments. Members may obtain additional information on page 35 of the MSFC Member Handbook.

MedStar Family Choice staff may read the member’s medical records to make sure that they are getting the care they need.

E. ANTI-GAG PROVISIONS

Providers are not restricted from discussing with or communicating to a member, member, subscriber, public official, or other person information that is necessary or appropriate for the delivery of health care services, including:

(1) communications that relate to treatment alternatives including medication treatment options regardless of benefit coverage limitations;
(2) communications that is necessary or appropriate to maintain the provider-patient relationship while the member is under the provider’s care;

(3) communications that relate to a member's right to appeal a coverage determination with which the provider or member does not agree; and

(4) opinions and the basis of an opinion about public policy issues.

The provider agrees that a determination by MedStar Family Choice that a particular course of medical treatment is not a covered benefit pursuant to the member's coverage plan shall not relieve the provider from recommending such care to the member as he/she deems to be appropriate nor shall such benefit determination be considered to be a medical determination.

The provider must inform the member of their right to appeal a coverage determination pursuant to MSFC’s grievance procedures and according to law.

Providers contracted with multiple District Medicaid Programs are prohibited from steering members to any one specific MCO.

F. ASSIGNMENT AND REASSIGNMENT OF A MEMBER

Enrollment packages will be sent to the head of the household for each group of members in a family unit. Eligible members will have the opportunity to review and select a Managed Care Organization (MCO) and may advise the District of their primary care provider (PCP) preference. If members do not select a MCO during the thirty day period from the date of notice, DHCF, through its enrollment broker, will use an algorithm to automatically assign a member to an MCO.

Once members are enrolled in an MCO, they may elect to change MCOs within the first 90 days of auto-assignment or initial enrollment and on the anniversary date of their enrollment into the MCO for any reason.

G. PRIMARY CARE PHYSICIAN SELECTION

Each DC Healthy Families and DC Healthcare Alliance member enrolling in MedStar Family Choice (or are auto-assigned to MSFC by the District) must select a participating Primary Care Physician (PCP) of their choice. MedStar Family Choice and its providers are responsible for ensuring that new members select a PCP within 10 days of enrollment. Members who fail to designate a PCP, will be called by the MSFC Member Services team and assisted in selecting a PCP. If MSFC Member Services is unable to contact the member, MSFC will choose a PCP, if not previously provided services to the
member, if this information is available. MSFC will choose a PCP that has the capacity to accept the member and is also geographically accessible to the member. Geographic accessibility is defined as within 5 miles of a Member’s residence or no more than 30 minutes travel time.

MSFC members may change PCPs at any time. Members can call MSFC Member Services Monday-Friday 8:00am-5:30pm at (888) 404-3549 to change their PCP. PCPs may see MSFC members even if the PCP name is not listed on the membership card. As long as the member is eligible on the date of service and the PCP is participating with MSFC, the PCP may see the MSFC member. However, MSFC does request that the PCP assist the member in changing PCPs so the correct PCP is reflected on the membership card. The office should contact Member Services (888) 404-3549. The PCP office may also submit a PCP change form to Member Services, which is signed and dated by the member wishing to change PCPs. This form is available on the MSFC website. MedStar Family Choice’s Outreach staff is available to providers Monday through Friday from 8:00a.m. to 5:30 p.m. (855) 210-6203 to answer any eligibility or PCP questions.

MedStar Family Choice mails member rosters to PCPs on a monthly basis. New member additions will be indicated on the report. This information changes daily and should not be used to determine member eligibility. Providers must verify through the IVR system operated by DHCF that members are assigned to MedStar Family Choice before rendering services. Providers may also call MSFC’s Provider Relations Service Department at (855) 210-6203 to obtain a monthly member roster. However, the roster should not be used to determine eligibility.

H. BECOMING A MEDSTAR FAMILY CHOICE PRACTITIONER OR PROVIDER

MedStar Family Choice recognizes the importance of maintaining a provider network comprised of the necessary provider types to ensure that all of the covered health care benefits of our members our met. Our robust network of participating providers has afforded our members the convenience of seeing providers who are geographically accessible. For each of our member’s there will be at a minimum two (2) Primary Care Physicians available to them that are geographically available within the District’s guidelines. Our network providers understand and are respectful of health-related beliefs, cultural values, and communication styles, attitudes and behaviors of the cultures represented in the Member population.

A provider directory will be available in print form and electronically via the website. Our provider relations staff will educate the provider network with regards to appointment time requirements and access to practitioners.

**Initial Credentialing**
All providers must be credentialed in the MSFC network before providing covered services to MSFC members. Providers interested in Participating in the MedStar Family Choice Provider Network should contact the Provider Relations Department at (888) 210-6203 Monday-Friday 8:00am to 5:30pm to request contracts and an application package. If providers are participating with CAQH, providers may request the MSFC Provider Relations Department to send them a CAQH Data Form and Attestation for completion. If providers are not participating in CAQH, the provider may use the paper Universal Credentialing Datasource (UCD) Application. This can be obtained on CAQH’s website https://caqh.geoaccess.com/oas/ or can be obtained by contacting Provider Relations. The completed CAQH data form and signed and dated Attestation or full paper application must be submitted to MSFC for processing. Signed participation agreements must accompany the CAQH form in order for the credentialing process to begin.

MedStar Family Choice complies with NCQA guidelines and guidelines outlined by DHCF and District of Columbia law regarding credentialing timeframes.

The credentialing process is completed within the District of Columbia requirements upon receipt of all required documents. Providers may contact the Provider Relations Department for a status on the submitted application. Providers will also be subject to a site audit if the office location is not currently recognized as an approved site in the network.

Each Provider who applies for participation within the MedStar Family Choice Provider Network must provide documentation to satisfy the following criteria:

- A completed CAQH data form or CAQH credentialing application including a signed and dated Attestation

- Completion of baccalaureate education or the equivalent and post-baccalaureate medical training from accredited schools and subsequent internship and residency training of at least three years from ACGME accredited programs appropriate to the practice specialty, or from programs completed in the Royal College of Canada, United Kingdom, South Africa, Australia, Ireland or New Zealand. Physician Assistants with an Associate Degree from a Physician Assistant Program will meet the education requirement.

- Current unrestricted license to practice medicine in the jurisdiction where they practice
- Medical liability insurance coverage. Minimum liability amounts for MedStar Family Choice are $1,000,000 per claim, $3,000,000 per aggregate

- Current unrestricted Drug Enforcement Agency (DEA) license and an unrestricted CDS license, if applicable

- No current suspension, revocation, or limitation of licensure in any jurisdiction

- No current sanctions by Medicare or Medicaid

- Current, unrestricted privileges at one of the MedStar Family Choice participating hospitals

- Specialists must be Board Certified or Board Eligible or fall under one of the Special Cases regarding specialty credentialing (see Special Cases definitions). While individual primary care providers are not required to be board certified, MedStar Family Choice has established a target of 80% board certification for its primary care panel. Allied Health Care Providers must be certified in their respective specialty.

- Certified Nurse Midwives must have designation of and acknowledgment for collaboration by an obstetrician who is an active member of the MSFC network and on staff at a MedStar Family Choice participating hospital with admitting and clinical privileges in obstetrics. The Certified Nurse Midwife must also be in practice in collaboration with the above-named obstetrician in accordance with the policies specific to Certified Nurse Midwives and the general policies governing Allied Health Professionals developed and approved by the Department of Obstetrics and Gynecology, the Medical Staff and the Board of Trustees of the MSFC participating hospitals.

- Practitioners shall not be denied participation in the MedStar Family Choice network based on their race, ethnic/national identity, gender, age, sexual orientation, religion, or any protected category under the federal Americans with Disabilities Act, or on the type of procedure or patient (e.g., Medicaid) in which the practitioner specializes. In addition, MedStar Family Choice does not discriminate against practitioners who specialize in conditions that require costly treatments, who serves high-risk populations, or who is acting within the scope of their license or certification under state law.

- Primary Care Providers treating members under the age of 21 years old must submit a copy of their DC HealthCheck training as part of the credentialing process. Training must be current in order to be considered for participation in the health plan.
**Recredentialing**

MedStar Family Choice, in accordance with state and federal regulatory authorities, credentialing authorities, and other accrediting body (NCQA, CMS, etc.), requires recredentialing of providers every three years. If providers do not have a current and up to date CAQH record, or they do not participate with CAQH, the providers will be contacted several months prior to the actual reappointment date to begin the recredentialing process.

All practitioners are sent written notification of initial credentialing and recredentialing decisions. The Provider Relations Department will also perform a site audit of provider offices every three years. MSFC will notify the office in advance to schedule the audit. A site audit may occur more frequently if MSFC receives member complaints regarding the office. During the time a provider is contracted with MedStar Family Choice, the provider may have changes in office locations, Tax-ID number, phone number, etc. All provider changes must be submitted to the MedStar Family Choice Provider Relations Department by faxing the information to (202) 243-5497. Provider Relations performs site audits on all providers who open a new office location before any demographic changes are made to the provider’s individual and group record in the credentialing database. Members should not be seen in the new location until the site visit has been performed Complete change requests are processed within 14 days of receipt. If Provider Relations must obtain other documents or clarification regarding the change, this will cause a delay in the processing time.

**Provider Performance Data**

Providers agree that MedStar Family Choice may utilize a provider’s performance data in numerous ways including but not limited to:

- Recredentialing
- Pay for Performance
- Quality Improvement Activities
- Public reporting to consumers
- Preferred status designation in the network (tiering) for narrow networks
- Reduced member cost sharing
- Other quality activities

**I. PROVIDER TRAINING**

Within one month of entering the MSFC network, all new providers will be trained regarding the EPSDT (Early Periodic Screening, Diagnosis and Treatment) Program and
the IDEA (Individuals with Disabilities Education Act). EPSDT training will cover the EPSDT periodicity schedule, compliance requirements, the Salazar Order/Consent Decree and subsequent court orders. IDEA training will provide an overview of the roles and responsibilities of the schools Early Intervention Program, providers. Such training will be offered on a quarterly basis thereafter. Additional training will be provided per the provider’s request.

As required by DHCF, HealthCheck Providers must complete the web-based HealthCheck training within thirty (30) days of joining the MCO network and at least every two (2) years thereafter. Compliance with Health Check training shall also be a requirement for re-credentialing with the MCO.

J. PROVIDER REIMBURSEMENT

Payment is in accordance with the provider contract with MedStar Family Choice (or with the management groups that contract on the provider’s behalf with MedStar Family Choice). In accordance with the Section 1902(a)(37)(A) of the Social Security Act and D.C. Code§ 31-3132., MSFC 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, MSFC shall reimburse providers for covered services within 30 days after receipt of all reasonable and necessary documentation. MSFC shall pay interest on the amount of the clean claim that remains unpaid 30 days after the claim is filed. Providers must verify through the IVR, operated by DHCF that members are assigned to MedStar Family Choice before rendering services. Providers may also call MSFC at (855) 210-6203 to obtain the member’s PCP.

Self-Referred and Emergency Services- DC Healthy Families

Out-of-network hospitals will be paid by MSFC, for all emergencies, authorized covered services and post stabilization care services provided outside of the established network. MSFC cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

MedStar Family Choice will reimburse out-of-plan providers for the following services for members enrolled in DC Healthy Families:

- Emergency services provided in a hospital emergency facility;
- Family planning services except sterilizations

DC Healthcare Alliance members do not have out of network benefits. Family planning services may be provided by any in-network provider.
**Out-of-Network Providers for Services- DC Healthy Families Program Only**

When a covered medical service is not available within MSFC’s network, adequate and timely coverage of services will be provided out of the network. MSFC will coordinate with out-of-network providers with respect to payment and ensure that cost of the services and transportation to the member is no greater than it would be if the services were furnished within the network.

**Second Opinions**

If a member requests one, MSFC will provide for a second opinion from a qualified health care professional within our network. For DC Healthy Families only, if one is not available within the MSFC network we will arrange for the member to obtain one outside of our network at no cost to the member. Second opinions for Alliance members must occur within the network.

**Members with Special Healthcare Needs- DC Healthy Families**

Members with Special Health Care Needs will be contacted directly by MSFC to ensure enrollment with a new provider. In the event that a member with Special Health Care Needs is unable to secure a new network provider within 3 business days, MSFC will arrange for covered services from an out-of-network provider at a level of service comparable to that received from a network provider until MSFC is able to arrange for such service from a network provider. These services will be paid for at a rate negotiated by MSFC and the non-network provider.

If MSFC denies, reduces, or terminates the services, members have an appeal right, regardless of whether they are a new or established member. Pending the outcome of an appeal, MSFC must reimburse for services provided.

**K. CONTRACT TERMINATIONS**

If a provider decides that he/she no longer wishes to be a part of the MedStar Family Choice network, the provider must submit a termination letter and allow 90 days from the time your letter is received by the Provider Relations Department.

**Primary Care Providers**

To ensure, continuity of care, MedStar Family Choice must notify members within 15
days after issuance of the termination or within 30 days prior to the Primary Care Provider termination date. The notice will provide Members with information regarding the assistance in securing a new PCP, and where, and how to obtain assistance. The notice will also notify members of the date the PCP’s contract will terminate, arrangements for transferring Private Health Information (PHI) and future contact information for the PCP. The members will be given the option of choosing a new PCP or being assigned to one. For members assigned to PCP groups, the members are given notice that the provider within the group has left the practice. Members will remain assigned to the group unless the member calls Member Services to change PCPs. In some cases, members who are in active treatment may be able to continue seeing the PCP for up to 90 days after the termination. The provider should contact Care Management to discuss continuity of care issues. In order for MSFC to be in compliance with the District requirements, it is imperative that providers promptly notify MSFC of any and all changes to the provider’s practice.

**Specialist Providers**

For specialists that are terminating, MedStar Family Choice will notify members in active care with the provider within 15 days of issuance of the termination or within 30 days prior to termination, of the provider’s termination with the health plan. The member will be advised to select a new specialist provider, and to contact Member Services if they require assistance. In some cases, for those members in active treatment, MedStar Family Choice and the terminating provider may agree to extend the member’s care under the terminating provider for a period up to 90 days. For OB/GYNs, if members are in their second or third trimester continuity of care provisions may extend to the post-partum period. There are out of network limitations for DC Healthcare Alliance members. The provider should contact Care Management to discuss continuity of care issues. In order for MSFC to be in compliance with the District requirements, it is imperative that providers promptly notify MSFC of any and all changes to the provider’s practice.

**L. CONTINUITY OF CARE**

MSFC is responsible for providing ongoing treatments and patient care to new members until an initial evaluation is completed and MSFC develops a new plan of care.

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

- Appropriate service referrals to specialty care providers are to be provided in a timely manner.
Authorization for ongoing specialty services will not be delayed while members await their initial PCP visit and comprehensive assessment. Services comparable to those that the member was receiving upon enrollment into MedStar Family Choice are to be continued during this transition period.

If, after the member receives a comprehensive assessment, MSFC determines that a reduction in or termination of services is warranted, we will notify the member of this change at least 10 days before it is implemented. This notification will tell the member that he/she has the right to formally appeal to MedStar Family Choice by calling MedStar Family Choice Appeals Department at (855) 210-6203. In addition, the notice will explain that if the member files an appeal within ten days of our notification, and requests to continue receiving the services, then MSFC will continue to provide these services until the appeal is resolved. The provider will receive a copy of this notification.

M. SPECIALTY REFERRALS

MSFC will maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits as required by the District. If a specialty provider cannot be identified, contact the MSFC Care Management Department at (855) 210-6203. If an appropriately qualified provider is not available within the network; the Care Management Department will arrange for an out of network authorization if medically necessary. For DC Healthcare Alliance members, out of network services are not covered.

N. TRANSPORTATION—DC Healthy Families Only

Providers may contact MSFC at (866) 208-7357 to assist MSFC members in accessing non-emergency transportation services. Non-emergency transportation will be provided by MSFC. MedStar Family Choice, will make reasonable efforts to accommodate logistical and scheduling concerns of the provider and members. MSFC requests that providers give three (3) business days advance notice for non-EPSDT appointments and the day before for urgent and EPSDT appointments for transportation requests.

MSFC will provide public transportation, Smart Trip Cards, wheelchair vans, and ambulances. The type of transportation provided will depend on the medical need of the member.
Section II

Provider Responsibilities
A. ROLE AND RESPONSIBILITIES OF MSFC PRIMARY CARE PROVIDERS

MedStar Family Choice Primary Care Providers are responsible for managing the health care needs of their patient panel, including appropriate referrals to participating MedStar Family Choice Specialists when medically necessary. In most cases, prior-authorization for routine referrals is not required. Services requiring prior-authorization are listed in the next section, as well as on the Quick Reference Guide for MedStar Family Choice.

MedStar Family Choice requires that providers maintain a clean office environment that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities Act (ADA) standards. The member’s wait time should be no more than 45 minutes, and emergency cases should be seen immediately.

Primary Care Providers will provide the following services to all MSFC patients who have selected him/her as their physician in order to manage the patients’ healthcare needs:

1. Initial appointments to new members 21 and over within 30 days of request

2. Routine office visits and office treatments for new and established patients within 30 days of request. Routine appointments should include the following:
   a. Diagnosis and treatment of health conditions and problems that is not urgent
   b. Routine and well-health assessments of adults 21 and older

3. MedStar Family Choice providers must offer hours of operation to MSFC members that are no less in number or scope than the hours of operation offered to commercial or other Medicaid patients. The following DHCF appointment guidelines must be followed:
   a. Well-child assessments, routine and preventative primary care appointments: 30 days from request
   b. Routine specialist follow-up appointments: 30 days from request
   c. High Risk Newborn visits: Within 48 hours of discharge from the birthing center or birthing hospital
   d. Lab, X-ray: 30 days from request
   e. Urgent care requests: 24 hours from request
   f. Initial assessment of pregnant and postpartum women and those requesting family planning services: 10 days from request

4. Acute evaluation and treatment of medical emergencies in your office or in the emergency room.
5. Periodic complete physicals and preventive medical exams:
   a. Pre-Operative physicals, history and clearance
   b. Well Child exams and periodic adult physical exams
   c. Sports, school and camp physicals

6. Pelvic exams, anoscopy, flexible sigmoidoscopy (if credentialed/certified),
   EKG’s, emergency splinting, ear irrigation, suturing, minor surgery including
   I&D, venipuncture, spirometry, and any other diagnostic or therapeutic
   services currently being offered to patients in office as part of the office’s
   normal scope of practice.

7. All routine injections and immunizations required by AAP, CDC, AATD, ASM,
   EPSDT including, but not limited to:
   - DTaP
   - OPV/IPV
   - Hepatitis B
   - Haemophilus Influenza B
   - Influenza
   - Varicella
   - Pneumovax
   - Tetanus Toxoid
   - PPD
   - MMR
   - Prevnar
   - Meningococcal
   - Rotavirus
   - Hep A
   - Gardisil
   - HPV

8. Vaccines for MSFC members age 18 and younger should be obtained
   through the Vaccines for Children Program (VFC). Vaccinations covered by
   the VFC program will not be reimbursed by MSFC. Please contact the VFC
   program at (202) 576-7130 for additional information.

9. All hospital primary care medical services including initial hospital care,
   subsequent hospital care, initial inpatient hospital consultations, follow-up
   inpatient consultations, and inpatient critical care.

10. Sub-acute care and nursing home care, including initial admission, H&P,
    initial orders, and subsequent nursing home care.

11. All other coordination of care, counseling, patient education, discussion with
    family members, paperwork, risk factor reduction interventions and health
    risk assessments.

12. Primary Care Providers are contractually required to provide or arrange
    coverage to their members 24 hours a day, seven days a week to ensure
    members have timely access to necessary care, including emergency care.
    Offices must have an answering service available to members on how to
    contact the practitioner for urgent or emergency conditions.

13. When requesting lab and radiology tests, physicians must use the
    appropriate referral forms.
14. When ordering medications or writing prescriptions, physicians need to reference the MSFC formulary and prior-authorization list as appropriate. When ordering medications for Alliance members, the Alliance formulary must be used.

15. PCPs shall notify MSFC at least thirty (30) days in advance of PCP reaching maximum capacity for new patients.

16. PCPs shall perform annual mental health and substance abuse screenings. The PCP shall use the ASQ-3, PSC, PHQ9 or other brief mental health screening tools. Members with positive screens should obtain a timely appointment from a Mental Health provider.

17. PCPs who receive appropriate training may be able to provide fluoride varnish to children who are age 2 and under. Contact Provider Relations for additional information.

B. ROLE AND RESPONSIBILITIES OF MSFC SPECIALIST PROVIDERS

Members with Special Health Care Needs, may choose as their PCP, a specialist who has the experience and expertise in treating individuals with special health care needs. This specialist provider must be willing and have the capacity to accept the member. This must be coordinated with the MSFC Care Management Department prior to becoming effective.

The responsibilities of participating MedStar Family Choice Specialty Care Physicians are as follows:

1. Provide Specialty services indicated by referral from the Primary Care Provider.

2. Work closely with the Primary Care Provider to ensure continuity of medical care and recommend appropriate treatment programs as well as provide written consultation reports to the referring physician.

3. Obtain pre-authorization for procedures requiring authorization from MedStar Family Choice Care Management Department. This also includes completing a Universal Referral Form.

4. Collect laboratory specimens in office or send members to a participating lab service center as needed. Providers must use a lab requisition form when ordering laboratory testing to guarantee proper routing of results and ensure that the patient is not billed for the service.
5. Refer members for radiology by completing the Uniform Consultation Referral Form or a script to a contracted radiology site.

6. Refer members to contracted vendors for Durable Medical Equipment (DME) and follow MSFC authorization requirements.

7. Refer members for Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) by completing the Uniform Referral Form to the contracted rehabilitation sites.

8. Contact the Primary Care Provider if additional services outside the specialist’s practice are required.

9. Comply with MSFC Quality Improvement and Case Management for concurrent review and discharge planning.


11. When ordering medications or writing prescriptions, providers must reference the MSFC formulary and obtain prior-authorization as required.

12. MedStar Family Choice providers must offer hours of operation to MSFC members that are no less in number or scope than the hours of operation offered to commercial or other Medicaid patients. The following DHCF appointment guidelines must be followed:

   - Well-child assessments, routine and preventative primary care appointments: 30 days from request
   - Routine specialist follow-up appointments: 30 days from request
   - High Risk Newborn visits: Within 48 hours of discharge from the birthing center or birthing hospital
   - Lab, X-ray: 30 days from request
   - Urgent care requests: 24 hours from request
   - Initial assessment of pregnant and postpartum women and those requesting family planning services: 10 days from request

C. CLINICS AS PROVIDERS

Members may designate a clinic as a PCP. Clinics must comply with the capacity standards. Each Full-time Equivalent PCP in the clinic may have no more than 2,000 total patient load of Medicaid and Alliance Members.
D. ROLE AND RESPONSIBILITIES OF THE OBSTETRICAL AND GYNECOLOGICAL PROVIDER

Routine Care

Under this benefit, a female member age 12 and over may opt to have all her routine gynecological care, including her annual gynecological examination and Pap smear, as well as any other routine gynecological care performed by either her PCP or a participating gynecologist.

If the member elects to have her annual examination or other gynecologic-related services performed by a participating gynecologist, the protocol below must be followed:

- The member must use a participating OB/GYN from the MedStar Family Choice Specialist Network.
- No referral is necessary for visits which are annual, routine or for other gynecologic-related problems
- Following each visit for gynecological care, the OB/GYN must ensure clinical communication with the PCP concerning any diagnosis or treatment rendered.
- The OB/GYN must confer with the member’s PCP prior to performing any diagnostic procedure that is not in the scope of routine office care.
- The OB/GYN shall contact the member’s PCP for all referrals for other specialty care (e.g., oncologist, neurologists, therapists, etc.).

Obstetrical Care for Normal OB Patients

Minimum Diagnostic Procedures: The initial diagnostic procedures may be done at the Primary Care Provider’s office and the results forwarded to the OB physician. Note: A participating OB/GYN does not need a global OB referral to perform these services.

Upon confirmation of pregnancy, the DC Collaborative Perinatal Risk Screening must be completed and forwarded as required by the District. MSFC requests that providers also send a copy of this form to the MSFC Care Management Department. The fax number is (202) 243-5496. MSFC will review the assessment and contact the Member to offer appropriate services and referrals. Pregnant members who are less than 28 weeks pregnant will be offered membership into the Momma and Me Program. This Program
is designed to incentivize members to be compliant with pre-natal, post-partum, health education, and well-baby visits.

Minimum Diagnostic Procedures

- Antibody Screen (Rh negative patients and Medical Assistance Patients)
- Blood Type
- Hematocrit
- Hemoglobin
- Hepatitis B Surface Antigen
- HIV with Counseling and Consent (Should be noted if recommended and patient refuses)
- Pap
- Rh
- RPR
- Rubella Screen
- Sickle Cell Screen for African-American women
- Testing for routine STDs- Chlamydia and GC
- Vaginal culture for Group B Strep at 34-37 weeks.
- Glucose challenge test (1ºGTT) Complete by 30 weeks for Medical Assistance patients
- AFP - Alpha Feto Protein performed between 15 - 18 weeks.
- Hematocrit (and RPR for Medical Assistance patients) repeated by 36 weeks.
- Each visit should show evidence of urine screen for glucose and protein.
- In the Rho(d) negative patient, the Rh immune globulin (Rhig) 300 grams IM should be given at 28-32 weeks gestation, unless the father is Rh negative. (This is to be given in the OB provider’s office)
- Up to three sonograms - to be done in office or at an in-network MedStar Family Choice radiology facility. If the OB selects to use the in-network radiology facility, a Uniform Consultation Referral Form or script must be completed and sent to both the radiology facility and MSFC Care Management Department. If more than 3 sonograms or additional testing/procedures need to be performed, authorization is required.

**Note:** All laboratory services must be sent to a participating lab. Please be sure to use a lab requisition form when sending a patient for lab services.

MedStar Family Choice providers must offer hours of operation to MSFC members that are no less in number or scope than the hours of operation offered to commercial or other Medicaid patients. Initial assessment of pregnant and postpartum women and those requesting family planning services: 10 business days from request (DHCF requirement).

Frequency and Criteria of Office Visits should closely model the following schedule:
- Monthly for the first trimester
- Every 4 weeks through 32 weeks
- Every 2-3 weeks until 36 weeks
- Every week after 36 weeks

**Initial visit:**
- Evidence of prenatal education to include: Diet, smoking and alcohol and drug usage
- Obstetrical history
- Family/social history
- Physical evaluation
- Genetic/birth defect screening with appropriate referrals and authorizations

**Each subsequent visit:**
- Evidence within the record of standard physical findings with appropriate diagnosis, treatment and follow-up for abnormalities including: fetal height and fetal heart rate
- Monitoring BP
- Identify high-risk patients and refer as necessary after approval from the PCP, i.e., nutritional counseling for gestational diabetes, etc.
- Monitoring weight

**Counseling/Education for:**
- HIV screening discussed, offered, and/or completed
- Substance abuse

**Post Partum:**
- Post partum examination should be scheduled between 4 and 6 weeks after delivery. This should include a clearly documented family planning discussion (including patient’s plans for birth control) and discharge back to PCP.

**High Risk OB Patients**

Conditions in mothers associated with high risk newborn status, include, but are not limited to one or more of the following characteristics:
- Medical or obstetrical complications
- Inadequate or no prenatal care
- Maternal age less than 18 years
- Suspected or diagnosed mental illness
- Suspected or diagnosed physical or developmental conditions or developmental disability or delay
- Suspected or diagnosed substance abuse
- Evidence of poor infant-maternal bonding
- Homelessness
- Evidence of poor parenting skills or,
- History of involvement with Child and Family Services Agency
- If any further diagnostic testing is required, it may need to be approved through Care Management at (855) 210-6203 so that the care is coordinated and case managed, and/or proper referrals to ancillary services can be made. Please refer to the MSFC authorization requirements for information regarding OB services requiring prior authorization.

Prior to discharge, the mother must have designated a PCP for the newborn. The PCP must be available and have registered the newborn as a patient and scheduled the first appointment.

**Home Visiting Outreach for High Risk Newborns**
Each high-risk newborn will receive a home visit from a registered nurse licensed in accordance with the D.C. Health Occupations Regulatory Act and its implementing regulations within forty-eight (48) hours of discharge from the birthing hospital or birthing center.

**E. REPORTING COMMUNICABLE DISEASE**

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. according to the District’s Communicable Disease Reporting Requirements

- With respect to patients with tuberculosis, you must:
  - Report each confirmed or suspected case of tuberculosis to the DC Tuberculosis Control Program within 48 hours.
  - Provide periodic reports on Members in treatments, and notify the DC Tuberculosis Control Program of Members absent from treatment more than thirty (30) days.

- Providers must ensure that all cases of the following diseases that are detected or suspected in an member by either a clinician or a laboratory are reported to the Sexually Transmitted Disease Division, DC DOH:
- Sexually transmitted diseases

- The AIDS Surveillance Division of DC DOH should be contacted to report
  - Communicable diseases, like HIV

- Blood Lead Levels among Children under the age of six
  - In accordance with the District’s Childhood Lead Poisoning Screening and Reporting Legislative Review Emergency Act of 2002 D.C. Code§ 7-871.03 (2006), results of all blood lead screening tests should be submitted to DHCF and the Department of Health, Childhood Lead Poisoning Prevention Program within seventy two (72) hours after identification.
  - Refer a child so identified for assessment of developmental delay, and coordinate services required to treat the exposed child with the lead inspection and abatement services
  - Lead Screenings must be completed at 12 months and 24 months of age per HEDIS requirements

- Comply with the reporting requirements of the District of Columbia registries and programs, but not limited to the Cancer Control Registry

- Infants, Toddlers, and School-Age Children Experiencing Developmental Delays
  - Providers should report to the Early Care and Education Administration D.C. Infants and Toddlers with Disabilities Office (ITDO) and to MSFC, members who are infants, toddlers, and school-age children whose developmental assessment components of their EPSDT periodic or interperiodic exam reveals evidence of developmental delay.

- Other Reportable Diseases and Conditions
  - Reports should be submitted to the Bureau of Epidemiology and Disease Control DC Department of Health (DOH) regarding either children or adults with vaccine-preventable diseases.
  - An outbreak of a disease of known or unknown etiology that may be a danger to the public health is reportable immediately by telephone.
F. APPOINTMENT SCHEDULING

In order to ensure that MedStar Family Choice members have every opportunity to access needed health related services PCPs must develop collaborative relationships with the following entities to bring members into care:

- MedStar Family Choice;
- Specialty care providers;

Prior to any appointment, providers must call the District of Columbia Government Medicaid IVR, dial (202) 906-8319 (inside DC Metro area) or (866) 752-9233 (outside DC Metro area) to verify eligibility and MCO enrollment. This procedure will assist in ensuring payment for services.

Initial Health Appointment for Adult and Pregnant MSFC Members

Primary care providers must offer new MSFC members ages twenty one (21) and over an initial appointment within forty-five (45) days of their date of enrollment with the PCP or within thirty (30) days of request, whichever is sooner. Initial appointments for pregnant women or Members desiring Family Planning Services shall be provided within ten (10) days of the Member’s request.

During the initial health visit, the PCP will be responsible for documenting a complete medical history and performing and documenting results of an age appropriate physical exam.

In addition, at the initial health visit, initial prenatal visit, or when physical status, behavior of the member, or laboratory findings indicate possible substance abuse, you are to perform a substance abuse screening using approved DHCF screening instrument as appropriate for the age of the member.

Wellness Services for Children Under 21 Years

All new MSFC providers will be trained on EPSDT services within 1 month of entering the MSFC network.

Appointments for initial EPSDT screening shall be offered to new MSFC members within sixty days (60) of the Member’s enrollment date or at an earlier time if an earlier exam is needed to comply with the periodicity schedule or if the child’s case indicates a more rapid assessment or a request results from an Emergency Medical Condition. The initial screen must be completed within three (3) months of the Member’s enrollment date, unless it is determined that the new Member is up-to-date with EPST periodicity
schedule. All EPSDT screens, laboratory tests, and immunizations should take place within thirty (30) days of their scheduled due dates for children under the age of two (2) and within sixty (60) days of their due dates for children age two (2) and older. Periodic EPSDT screening examinations shall take place within thirty (30) days of a request.

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

- Making a specialty referral when a child is identified as being at risk of a developmental delay by the developmental screen required by EPSDT; is experiencing a delay of 25% or more in any developmental area as measured by appropriate diagnostic instruments and procedures; is manifesting atypical development or behavior; or has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay; and
- Immediately referring any child thought to have been abused physically, mentally, or sexually to a specialist who is able to make that determination.

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

**Individual with Disabilities Education Act (IDEA)**

Early intervention Providers are responsible for performing health related IDEA services to children under age 3. Providers are also responsible for performing IDEA multidisciplinary assessments to determine IDEA eligibility and providing health related IDEA services for children 3 years of age and older unless and until these services are provided by DCPS. Providers responsible for providing IDEA services should include those who provide rehabilitation services for improvement, maintenance, or restoration of functioning, including respiratory (including home-based), occupational, speech, and physical therapies. All new MSFC providers will be trained within 1 month of entering MSFC’s network.

If it is determined that a Member qualifies for IDEA services, IDEA multidisciplinary assessments for infants and toddlers at risk of disability should be completed within 30 days of request. Any needed treatment should begin with 25 days upon receipt of the completed and signed Individualized Family Service Plans (IFSP) assessment.

**EPSDT Outreach**

For children 0-2 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, the provider 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, and by telephone.

Notify the MSFC Outreach unit at (855) 210-6203 for assistance with outreach as defined in the Provider Agreement.

Schedule a second appointment within 30 days of the first missed appointment.

Within 10 days of the child missing the second consecutive appointment, request assistance in locating and contacting the child’s parent, guardian or caretaker by contacting the Outreach Department.

After referring to the Outreach Department, work collaboratively with MedStar Family Choice and its Outreach Department to bring the child into care. This collaborative effort will continue until the child complies with the EPSDT periodicity schedule or receives appropriate follow-up care.

**Services for Pregnant and Post Partum Women**

MedStar Family Choice and MSFC providers are responsible for providing pregnancy-related services, which include:

- Prenatal risk assessment and completion of the DC Collaborative Perinatal Risk Screening
- Comprehensive prenatal, perinatal, and postpartum care (including high-risk specialty care);
- Development of an individualized plan of care, which is based upon the risk assessment and is modified during the course of care if needed;
- Case management services;
- Prenatal and postpartum counseling and education;
- Appropriate treatment and follow-up care for miscarriage
- Basic nutritional education;
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant women;
- Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers;
- Postpartum home visits;

The PCP, OB/GYN and MedStar Family Choice are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcome. Additionally, pregnant women, post-partum women and children up to age five (5) who are at risk for nutritional deficiencies or have nutritional related medical condition to the Special Supplemental Food Program for Women Infants and Children (WIC and DHCF). Results of tests conducted to ascertain nutritional status shall be submitted to the WIC agency. MSFC will direct all eligible members to the WIC program (Medicaid members are automatically income-eligible) and coordinate with existing WIC providers to ensure members have access to the special supplemental
nutrition program for women, infants and children or MSFC will provide these services. In connection with such referrals, necessary medical information will be supplied to the program for the purpose of making eligibility determinations.

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

Providers must:
- Schedule prenatal appointments in a manner consistent with the ACOG guidelines.
- Provide the initial health visit within 10 days of the request.
- Complete the DC Collaborative Perinatal Risk Screening for each pregnant member and submit it to DHCF and within 10 days of the initial visit.
- For pregnant members under the age of 21, refer them to their PCP to have their EPSDT screening services provided.
- Reschedule appointments within 10 days for members who miss prenatal appointments.
- Refer to the WIC Program.
- Refer pregnant and postpartum members who are substance abusers for appropriate substance abuse assessments and treatment services.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- Instruct pregnant member to notify the MCO of her pregnancy and her expected date of delivery after her initial prenatal visit.
- Instruct the pregnant member to contact the MCO for assistance in choosing a PCP for the newborn prior to her eighth month of pregnancy.
- Document the pregnant member’s choice of pediatric provider in the medical record.

**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;
- If a member elects to be discharged earlier than the conclusion of the length of stay, 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 provided.
Deliveries are not covered for DC Healthcare Alliance members.

**Home Visiting for High Risk Newborns**

Post-natal home visits are to be performed by a registered nurse, licensed in accordance with the DC Health Occupations Regulatory Act. Visits should be conducted within 48 hours of discharge from the birthing hospital or birthing center. The registered nurse should perform the following:

- An evaluation to detect immediate problems of dehydration, sepsis, infection, jaundice, respiratory distress, cardiac distress, or other adverse symptoms of the newborn;
- An assessment of the home environment
- Facilitate parent-child attachment, including newborn attachment
- Ascertain family resources, supports, and linkages, as well as family and parent risk factors
- Assess the diagnostic and treatment needs of the parent as well as the newborn, including assessment of need for post partum care and follow-up related to a physical condition mental illness or substance abuse condition
- An evaluation to detect immediate problems of dehydration, sepsis, infection, bleeding, pain, or other adverse symptoms of the mother;
- Blood collection from the newborn for screening, unless previously completed;
- Appropriate referrals and follow-up care for both the newborn and the parents/or who need post partum care and/or suspected of having a physical or mental health condition requiring further diagnosis and treatment
- Care coordination related to early intervention, WIC, and family support services through
- Any other nursing services ordered by the referring provider
- Ongoing follow-up throughout the first year of life

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

Unless MSFC provides 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.
G. SPECIAL NEEDS POPULATIONS

Health risk questionnaires, approved by DHCF, should be utilized to identify Special Needs populations within sixty days of enrollment. The District has identified certain groups as requiring special clinical and support services from their MCO. These special needs populations include, but are not limited to:

- Enrollees with Special Health Care Needs or with severe disabilities, including Enrollees with HIV/AIDS or other disabling conditions with a cognitive, biological, or psychological basis that result in, but are not limited to, the following:
  - The need for medical care or special services at home, place of employment or school;
  - Dependency on daily medical care, special diet, medical technology, assistive devices, or personal assistance in order to function; or
  - Complex conditions requiring coordinated services from multiple treatment Providers on a frequent basis.
  - Enrollees with complex Disease Management issues or complex psychosocial needs which could adversely affect their health status;
  - Enrollees with or at risk of serious life threatening conditions;
  - Enrollees with mental health care needs; and
  - Enrollees receiving services under the IDEA.
  - Enrollees with high-risk pregnancies including, but not limited to, those with:
    - Young maternal age;
    - Short inter-conceptional period;
    - Late onset of prenatal care;
    - Alcohol and drug abuse;
    - Domestic violence in the home;
    - Documented barriers to accessing health care; or
    - Maternal illness that may affect the birth of the fetus;

Services Every Special Needs Population Receives

If a member falls into one of the categories listed above or any condition defined as special needs, the PCP is required to contact the Case Management Department.

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

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

Individuals in one or more of these special needs populations must receive services in the following manner from MSFC and/or MSFC 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 MSFC 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 MSFC for sending members to specialty care networks.
- All of the MSFC 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**

A member of a special needs population who fails to appear for appointments or who has been non-compliant with a regimen of care may be referred to the Outreach Department for specific outreach efforts, according to the process described below.

If the PCP or specialist finds that a member continues to miss appointments, MedStar Family Choice must be informed. Within 10 days of either the third consecutive missed appointment, or the provider becoming aware of the patient’s repeated non-compliance with a regimen of care, whichever occurs first, the provider should notify the Outreach Department by completing the Outreach Department Referral Form. MSFC will attempt to contact the member by mail, telephone and/or face-to-face visit. The completed Outreach Service Referral Form and a copy of the letter will be faxed to the member’s PCP informing him or her of the unsuccessful contact. The Outreach Department and Case Management Department will work collaboratively to facilitate getting the member into care. If the member is contacted, the Wellness and Preventive Care Coordinators will assist the member with rescheduling another appointment. If the member is
pregnant, an appointment will be made within 10 days, and all other appointments will be scheduled as available but within DHCF requirements.
Section III

MedStar Family Choice
Care Management and Claims
A. OVERVIEW

The MedStar Family Choice Care Management Department includes Outreach, Utilization Management and Case/Disease Management. The Outreach staff will assist MSFC members and providers in ensuring that members obtain all necessary services. In addition to ensuring that members understand all of the preventive services they should obtain, the Outreach Department will work with non-compliant members to bring them into care and get them up to date on necessary preventive services. If transportation is a barrier for the member, transportation is available by contacting 866-208-7357. The Utilization Management staff will review pre-authorization requests for medical services. The Case Management and Disease Management staff will work with providers and assist them in managing the more complex members that require care coordination. Our Care Management Department can be reached Monday-Friday 8:00am-5:30pm at (855) 210-6203. Telephone messages or faxes received after normal business hours will be responded to on the next business day.

MedStar Family Choice also offers at no charge, health education classes on numerous health topics. Members are encouraged to participate in these classes.

For members with communication barriers, MedStar Family Choice offers interpreter services that can be used telephonically or in the provider office when needed.

There are procedures that providers must follow that will help ensure they receive payment for the services provided. This chapter also discusses how to verify eligibility, how to obtain prior-authorization and what services require prior-authorization. Claims filing procedures are also discussed in this Chapter. The information found in this chapter can also be found on the website at www.medstarfamilychoice.com.

B. OUTREACH SERVICES

The Outreach Department is available Monday-Friday 8:00am-5:30pm. MSFC can be reached at (855) 210-6203. Providers may also fax MSFC at (202) 243-5495. Voice messages and faxes received after hours will be handled the next business day.

New Members

New members will be contacted via telephone and letter reminding them of the need to schedule their appointments in the timeframes required by the District. In many instances, MSFC Outreach will perform a three-way call between the MSFC Wellness and Preventive Care Coordinator, the member, and the provider office to schedule an appointment on a date and time available for both the provider and member. It is the responsibility of the PCP office to provide an appointment for a new member in accordance with the above guidelines.
**Non-Compliant Members**

The MSFC Outreach Department assists providers with required outreach attempts for preventive care and member non-compliance. If providers are aware of non-compliant members, providers may contact the Outreach Department. The Outreach Department performs Outreach to non-compliant members in an attempt to bring members into care. Providers should use the Outreach Referral Form and fax this completed form to (202) 243-5495. If a provider continues to experience an issue with member non-compliance, the provider should contact Provider Relations. The Provider Relations Department will provide the documentation and requirements that must be followed prior to requesting a member dismissal. Special populations as defined in Section 2 have specific guidelines surrounding referrals to providers. Providers should be aware of referral guidelines surrounding these populations and ensure that members who miss appointments are referred to the outreach department timely and appropriately.

**C. CASE MANAGEMENT AND DISEASE MANAGEMENT**

MedStar Family Choice has a highly qualified staff of nurses and social workers to assist in caring for your patients. MSFC provides two types of Care Management services. These are **Complex Case Management** and **Disease Management**. Our nurses and social workers are responsible for specific programs, based on their areas of expertise.

**Complex Case Management**

Complex Case Management is a service provided by nurses, and social workers. These professionals are available to coordinate healthcare services for MedStar Family Choice members who require extensive use of resources or who need assistance to coordinate complex care. Complex Case Managers work closely with you, the provider, to ensure that members receive appropriate and timely medical services. Providers will receive updates and test results that MSFC receives on the provider’s patients. In addition, our Case Management staff will frequently contact our providers caring for these members to obtain clinical information and to ensure that the services needed were received. It is very important that MSFC hears back from providers as quickly as possible. Eligibility for complex case management is based on diagnosis and medical services. Complex case management is available for:

- Transplants
- Multiple chronic illnesses with high utilizations
- Catastrophic conditions/special needs requiring coordination of care
- Special needs populations who require assistance with coordination of care and are not covered by a Disease Management program.
- COPD members who have had at least one inpatient admission or 2 ER visits within 6 months, primarily related to this condition

**Disease Management:**
Disease Management is a service provided by nurses and social workers. This program focuses on members with specific chronic diseases. Disease Management was developed to assist a provider’s patients to better understand their disease, update them on new information about their disease and empower them with self care strategies. The program is designed to reinforce the provider’s treatment plan for the patient. Providers will receive updates and any test results that MSFC receives on the provider’s patients. In addition, MSFC staff may contact the provider to request clinical information or to verify that services were received. We do appreciate your prompt response to these requests. Disease Management is available for members with:

- Pediatric asthma
- Adult Respiratory
- Infants, toddlers, school-age children, and adolescents with evidence of developmental and mental disability and delay
- Adults with Hypertension and who have had at least one emergency department or hospital admission for Hypertension
- Adults with Cardiovascular conditions and who have had at least one emergency department or hospital admission for this condition
- Adults with mental illness and substance abuse-related conditions
- Children and adults with Diabetes and who have had at least one emergency department or hospital admission for Diabetes
- Pregnant Enrollees
- Persons with HIV/AIDS.

Members of MedStar Family Choice do not have to enroll; they are automatically enrolled when we identify them with one of these conditions. Membership in Complex Case Management and Disease Management programs is voluntary and members have the option to stop participating at any time. If providers would like to refer a member to one of these programs, please fax referral to (202) 243-5496 or call MSFC Case Management Department at (855) 210-6203. Any faxes or voice messages left after business hours will be handled the next business day.

Clinical Practice Guidelines for numerous medical conditions can be found on the MSFC website. Copies can also be obtained upon request by calling our Care Management Department.
D. HEALTH EDUCATION CLASSES

MedStar Family Choice Members are able to sign up for a variety of health education classes that are sponsored by MedStar Health. Education programs are ongoing and available weekends, days and evenings. All classes will be offered free of charge to eligible members. Class schedules are sent to members upon enrollment. In addition, schedules are sent to all PCP and OB/GYN offices on a regular basis. The schedule will also be available in physician offices, clinics, and will be made available from Member Service Representatives, Provider Relations, and Wellness and Preventive Care Coordinator, Case Managers. Additionally, the educational schedule will be highlighted in the member newsletter and on the internet at the MedStar Family Choice website. Transportation is also offered to members who attend these events.

Members who wish to quit smoking are encouraged to call the Quit Line for immediate assistance (1-800-QUIT-NOW). More information about MedStar Family Choice’s stop smoking program can be obtained by calling the Outreach Department at (855) 210-6203.

Please encourage MSFC members to take appropriate classes that would be of benefit for their particular condition or disease. Providers that refer Members to a health education class should document this in the Member’s chart.

E. EPSDT EDUCATION

Primary care providers are responsible for providing written and oral explanations of EPSDT services to members including pregnant women, parent(s) and/or guardian(s), child custodians and sui juris teenagers. This explanation shall occur on the first (1st) visit, and quarterly thereafter, and include information about the schedule for screens, laboratory tests and immunizations. The importance of the preventive aspects of the service and the benefits of early developmental and anticipatory guidance services should be emphasized for children under age three (3) to their caregivers.

F. INTERPRETER SERVICES

MSFC members with limited or no English proficiency must be assessed for translation service needs. MedStar Family Choice utilizes a language line and can provide for in-office translation services when necessary. Providers may contact the Care Management Department (855) 210-6203 to schedule telephonic translation services. Providers may contact Provider Relations (855) 210-6203 to schedule in office translation services with a contracted vendor. In addition, MSFC is contracted with La Clínica del Pueblo at (202) 462-4788 to perform interpretation services for MSFC members. Providers may contact La Clínica del Pueblo directly for these services.
Providers shall ensure that members are aware of the availability of professional interpreter services, assist in arranging for these services as necessary and ensure that the members are aware that the services are free of charge. Members are not encouraged to use a family member or friend for interpreter services. However, if the member refuses to utilize a professional interpreter, this must be documented in the member’s record.

Translation services are also available for those who are hearing impaired or who have limited vision. Providers may contact Provider Relations to schedule interpreter services.

For routine appointments, providers should give at least five (5) days prior notice for an interpreter request. For urgent appointments, providers must request assistance as quickly as possible.

G. ELIGIBILITY VERIFICATION

MedStar Family Choice Members are provided with an identification card indicating MedStar Family Choice as their chosen Managed Care Organization.
Providers must verify eligibility through the District of Columbia IVR system prior to rendering services to MSFC members. The phone number for the District of Columbia Government Medicaid IVR is (202) 906-8319 (inside DC Metro area) or (866) 752-9233 (outside DC Metro area). Providers can contact MSFC at (855) 210-6203 Monday-Friday 8:00am-5:30pm to identify the member’s PCP. MSFC members may change PCPs at any time. Members can call MSFC Member Services Monday-Friday 8:00am-5:30pm at 1-888-404-3549 to change their PCP. PCPs may see MSFC members even if the PCP name is not listed on the membership card. As long as the member is eligible on the date of service and the PCP is participating with MSFC, the PCP may see the MSFC member. However, MSFC does request that the PCP assist the member in changing PCPs so the correct PCP is reflected on the membership card. The office should contact Member Services (888) 404-3549. MedStar Family Choice’s Outreach staff is available to providers Monday through Friday from 8:00a.m. to 5:30 p.m (855) 210-6203 to answer any eligibility or PCP questions.

H. REFERRAL AND UTILIZATION MANAGEMENT PROCESS

MSFC encourages Primary Care and Specialty Providers to work together in managing a member’s care. This ensures that members receive the highest quality of coordinated, appropriate and member-sensitive care.
Specialists will provide consultative services and treatment or procedures on members based on the referral instructions from the member’s PCP. In most cases, prior-authorization for routine specialty care is not required. Those services requiring prior-authorization are detailed in this chapter.

The PCP should complete all sections of the Uniform Consultation Referral Form when referring the member to a MSFC specialist. Referrals to specialists should accompany members at the time of their appointment. A copy of the Uniform Consultation Form should also be mailed or faxed to MSFC Care Management at the following address:

MedStar Family Choice
Care Management Department
901 D Street SW
Suite 1050
Washington, DC  20024
Phone: (855) 210-6203
Fax:  (202) 243-5496

Referrals should not be sent to the Claims Department.

**Routine Referrals**

- Referrals are valid for 6 months from the date of issue. If a number of visits is not indicated on the referral, the referral is only valid for one visit.
- A specialist cannot refer to another specialist without authorization from the PCP. If a specialist determines that another specialist needs to be consulted, he/she must contact the patient’s PCP for verbal or written approval. After receiving approval, the specialist should complete the Uniform Consultation Referral Form. The Specialist must clearly indicate the PCP’s approval on the referral. **Exception: Specialists should directly refer members to participating providers for routine radiology, laboratory testing, rehabilitation, and DME services.**

**Behavioral Health Services**

MedStar Family Choice has contracted with ValueOptions to provide the covered behavioral health services available to MSFC members enrolled in DC Healthy Families. Providers wishing to provide these services to MSFC members must contact ValueOptions to become a participating provider and to obtain information referral and authorization guidelines at (877) 398-0124. The only behavioral health services covered for DC Healthcare Alliance members are those provided in a hospital for life threatening withdrawal from alcohol or narcotic drugs.
**Dental Services**

Dental services are provided to members through DentaQuest. Providers who are interested in providing covered dental services to MSFC members must contract directly with DentaQuest. Members are encouraged to select a primary dental provider upon enrollment into MedStar Family Choice. If one is not selected, a primary dental provider will be assigned. Members can see go to a dentist for routine dental care without a referral. Members can contact DentaQuest at (855) 388-6251 for assistance in changing their dental provider.

**Hospitals**

As of the date of this manual, the current participating hospital facilities include:

- Children’s National Medical Center
- Howard University Hospital
- MedStar Georgetown University Hospital
- MedStar National Rehabilitation Network
- MedStar Washington Hospital Center
- United Medical Center

Participating hospitals (as well as all other participating hospitals) can be found on the MSFC website at [www.medstarfamilychoice.com](http://www.medstarfamilychoice.com).

**Nurse Advice Line**

MSFC has a 24 hour/7 days a week nurse advice line available to members. While this does not take the place of the provider having 24/7 availability (coverage), it is another opportunity for members to discuss health concerns with a clinician. Members can call (855) 210-6204 to reach the Nurse Advice Line.

**Laboratory Referrals**

Laboratory Corporation of America (LabCorp) and Quest are the contracted laboratory vendors for MedStar Family Choice patients. Members should be referred to LabCorp or Quest draw stations if the physician office cannot draw in the office.

There are a few lab tests that can be performed in the physician’s office.

- Urologists are paid for the following codes when performed in the office setting: 81000, 81001, 81002, 81003, and 81005.

- Any participating provider may perform 87880 (rapid strep test), 83655 (blood lead testing), 87807 (RSV) and 87804 (Flu test) in a clinic or office setting
● Oncologists are paid for the following code when performed in an office setting: 85025

● Labs rendered in conjunction with the following services are paid without an authorization if performed at an in-network hospital: chemotherapy, labor and delivery, and ER’s (will be reviewed with ER claim).

● Labs provided in conjunction with an inpatient and outpatient survey procedure are paid under the procedure authorization.

**OB/GYN Referrals**

There is no referral required for MSFC OB/GYN visits that are annual, routine or for gynecologic problems or obstetrical care.

**Radiology Referrals**

MSFC has a network of radiology facilities. Please refer to the website for a network listing. If the provider office does not have access to the internet, providers may contact Provider Relations at (855) 210-6203 for a copy of the most current listing.

A radiology script or Uniform Consultation Form must be completed for all routine radiology services. Specialists should refer Members directly for radiology services. Members should not be sent back to their PCP for a referral. Prior authorization is required for some radiology services. A listing of procedures requiring prior authorization can be found later in this chapter.

Participating orthopedic providers may perform flat film x-rays in their office without authorization.

**Rehabilitation Referrals**

MSFC has a network for providing rehabilitation services (PT/OT/ST). Please refer to the MSFC website for a listing of participating sites (or contact Provider Relations for a written copy).

**Vision Services**

Members may self-refer to Advantica for all routine vision services and may contact Advantica directly for routine vision care and no referrals are required. Advantica also manages medical/surgical ophthalmology services. Providers wishing to provide services
to MSFC members for medical and surgical ophthalmology services must contact Advantica to become a credentialed provider and to obtain information on services requiring referrals and authorizations. Advantica is available Monday-Friday 8:00am-8pm and Saturdays 10am-5pm at (855) 210-6203.

**Urgent/Emergent Referrals**

For patients requiring immediate services, please call MSFC Care Management at (855) 210-6203.

**Utilization Management (Pre-Authorization)**

MedStar Family Choice follows a basic pre-authorization process: A member's physician forwards clinical information and requests for services to MedStar Family Choice by phone, fax or infrequently by mail. Providers may contact a case manager on business days from 8:00am-5:30pm at (855) 210-6203. The fax number is (202) 243-5496 and faxes are received 24 hours/day, 7 days /week. Faxes and voice messages received after hours will be addressed the next business day. The after-hours voice mail message includes information on how to contact MSFC for after hours needs. The after-hours message also contains a phone number for MSFC representative to be contacted for urgent pharmacy issues.

MSFC does not specifically reward practitioners or other individuals for issuing denials of coverage of care. In addition, there are no financial incentives for UM decision makers that would encourage decisions that result in underutilization. Clinical practice guidelines for certain conditions can be found on the website. Providers may also call the MSFC Care Management Department to request a written copy. Providers may request the UM criteria utilized for a specific case by calling the MSFC Care Management Department at (855) 210-6203.

All appropriate ICD-9s/CPT/HCPCS, along with supporting clinical information must be included in requests for pre-authorization. ICD-9/CPT/HCPCS codes in the medical record must match what is being requested for authorization and what is billed to MSFC. Requests for authorization can be included on the Uniform Consultation Referral Form with clinical information attached. MSFC’s experienced clinical staff reviews all requests. MedStar Family Choice pre-authorization decisions are based on the following criteria:

- MedStar Family Choice Protocols
- MSFC Pharmacy Policies and Procedures
- InterQual
- Federal Medicare and Medicaid Guidelines
- District of Columbia Health Care Finance Regulations and Contract Requirements
MSFC reserves the right to direct services to participating providers and facilities and providers agree to utilize these participating providers and facilities. Services outside the network are available only when they are not available within the network, for continuity of care reasons. Out of network services are not covered for DC Alliance members.

MedStar Family Choice's utilization management decision making is based on the medical necessity of the service and coverage under the benefits plan defined by DC Healthy Families and DC Healthcare Alliance requirements.

MedStar Family Choice requires up to fourteen (14) days to process a complete, non-urgent authorization request. Requests are considered complete when all necessary clinical information is received from the requesting provider. If a request is made by the provider or member, or if MSFC can show to DHCF that an extension is in the best interest of the member, an extension of fourteen (14) days may be granted. If the service requested is denied the provider may contact our Care Management Department to discuss the decision with the appropriate Physician Advisor.

For members with urgent authorization needs, physicians or a physician’s staff member should contact MedStar Family Choice Care Management at (855) 210-6203. A decision regarding urgent authorizations will be made within three (3) days of receiving the request.

A limited number of services require authorization from MedStar Family Choice Care Management before the patient receives care. Retrospective requests are reviewed against the above specified criteria and are not guaranteed approval. Retrospective services that could have been provided within the network are not likely to be retrospectively approved unless upon review the care was urgent/emergent, or not available from a participating provider.
Pharmacy

MSFC pays for a wide variety of medications, as outlined in our MedStar Family Choice Formulary. MSFC follows coverage District guidelines for the coverage of medications for DC Healthy Families and Alliance members.

The MSFC formulary for DC Healthy Families members is distributed upon joining MSFC and then annually. Formulary updates are sent to providers on a quarterly basis. The formulary is available on our website at www.medstarfamilychoice.com. If a physician feels it medically necessary to prescribe a medication not on the formulary, the physician may submit this request to MSFC. Such a request must include clinical documentation that supports the medical need for that specific medication. All non-formulary requests are reviewed by a physician advisor. MSFC does not guarantee coverage of medications, which are outside the guidelines set forth in the manual. Physicians may call MedStar Family Choice Care Management at (888) 210-6203 or fax the request to (202) 243-5496. Members will receive HIV/AIDS medications (anti-retrovirals) from one of the pharmacies in the District of Columbia Pharmacy Provider Network. A list of pharmacies can be found at www.doh.dc.gov/HAHSTA.

For DC Healthcare Alliance members, the covered medications must be filled at participating District of Columbia Pharmacy Provider Network pharmacies. The DC Healthcare Alliance formulary is listed on the MSFC website. If a physician feels it is medically necessary to prescribe a medication not on the Alliance formulary, the physician may submit this request to MSFC. Such a request must include clinical documentation that supports the medical need for that specific medication. All non-formulary requests are reviewed by a physician advisor. MSFC does not guarantee coverage of medications, which are outside the guidelines set forth in the manual. Physicians may call MedStar Family Choice Care Management at (888) 210-6203 or fax the request to (202) 243-5496.

Denials of Prescription Drugs

All denials of a prescription drug or pharmacy service will be sent to DHCF within 1 business day. If a member or provider disputes a denial of a prescription drug or pharmacy services through a Grievance or Appeals process, MSFC will fill a prescription for the following:

- 72 hours for prescription drugs that are administered or taken daily or more than once per day
- One full course for prescription drugs that are administered or taken less frequently than once per day
MSFC will also contact the provider who wrote the prescription to resolve any outstanding issues with respect to the prescription while the Grievance or Appeal is pending.

Requests for Synagis (palivizumab) require a completed Statement of Medical Necessity form and authorization is based on criteria set forth by the American Academy of Pediatrics Policy Statement. The updated form is available on the website each year. Providers may also contact Provider Relations for a copy of the form.

**Initial Request for Inpatient Authorization**

In situations where MSFC receives requests for inpatient authorization accompanied by clinical review, MSFC will communicate a decision within 24 hours (1 calendar day) of receipt of your request.

In situations where the initial hospital UM team inpatient authorization requests are NOT accompanied by clinical review, MSFC will follow the procedure of making one attempt to obtain clinical information in the first 24 hours (1 calendar day). If the hospital UM team is unable to provide the necessary clinical information within 24 hours of the initial UM team authorization request, the inpatient admission will be subject to denial for a lack of clinical information.

**Concurrent Review**

MSFC utilizes the following criteria to make concurrent review decisions:

- InterQual
- Medicare and Medicaid Guidelines
- District of Columbia Health Care Finance regulations and contract provisions
- MSFC benefit coverage
- Availability of services within the MSFC network
- MSFC UM Criteria Policy

MSFC reviews clinical documentation for timeliness of care and appropriate level of care. Clinical denial determinations may be issued by our physician advisors when a delay in care or delay in discharge planning creates an inpatient day that could have been avoided if service had been provided timely.

While MSFC care managers are available to assist with discharge planning, it is the responsibility of the inpatient facility to provide timely and appropriate discharge planning. Inpatient days that do not meet medical necessity as outlined in above criteria are the responsibility of the inpatient facility.
In situations where MSFC receives requests for additional urgent concurrent care that is accompanied by clinical review, MSFC will communicate a decision within 24 hours (1 calendar day) of receipt of your request.

In situations where MSFC receives requests for additional urgent concurrent care that is NOT accompanied by clinical review MSFC will make at least one attempt to request the outstanding clinical information. Clinical information not received within 24 hours (1 calendar day) of the authorization request will be subject to denial.

**Emergency Care- DC Healthy Families**

In accordance with the Emergency Medical Treatment & Labor Act (EMTALA), MSFC will pay claims for all medical screening examinations when the request is made for examination or treatment for an emergency medical condition, including active labor. MSFC does not consider a nurse exam or triage information as evidence of a medical screening exam.

In accordance with the Balanced Budget Act of 1997, MSFC pays for emergency services using a prudent layperson standard. An "emergency medical condition" is defined as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in placing the health of the individual or, with respect to a pregnant woman, or her unborn child in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

A copy of the MSFC autopay diagnosis list is included on the MSFC website. If the diagnosis is not listed on the auto-pay list, MSFC requires and fully reviews emergency department clinical documentation for evidence of a medical screening exam, prudent layperson guidelines, as well as evaluation of assigned treatment levels based on reasonable clinical care time guidelines.

MSFC does not specifically reward practitioners or other individuals for issuing denials of coverage of care. In addition, there are no financial incentives for UM decision makers that would encourage decisions that result in underutilization. Clinical practice guidelines for certain conditions can be found on the website. Providers may also call the MSFC Care Management Department to request a written copy. Providers may request the UM criteria utilized for a specific case by calling the MSFC Care Management Department at (855) 210-6203.
For members with urgent authorization needs, physicians or a physician’s staff member should contact MedStar Family Choice Care Management at (855) 210-6203. A decision regarding urgent authorizations will be made within 24 hours of receiving the request.

**Services Requiring Prior-Authorization**

NOTE: This is a list of services requiring prior-authorization for contracted providers and should not be used to determine whether a benefit is covered. Chapter 4 details the covered services provided under each product.
<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>DC Healthy Families</th>
<th>DC Healthcare Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions</td>
<td>Yes (only covered by MSFC in certain circumstances)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers (freestanding)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Anesthesia- Dental</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Audiology</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Birthing Centers</td>
<td>Yes</td>
<td>Deliveries are not a covered benefit.</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetes and Nutritional Consults</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Diagnostic tests/procedures-Hospital-based (excluding AFI, amniocentesis, BPP, EEG, fetal fibronectin, fetal stress tests and radiology)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dialysis</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>DME</td>
<td>Yes, if &gt;$1000 or for rentals &gt;90 days</td>
<td>Yes, if &gt;$1000 or for rentals &gt;90 days</td>
</tr>
<tr>
<td>DME Repairs</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Glucose monitoring, continuous (Rentals and purchase)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Health</td>
<td>Yes</td>
<td>Yes (skilled only)</td>
</tr>
<tr>
<td>Hospice (inpatient and outpatient)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
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<tr>
<td>TYPE OF SERVICE</td>
<td>DC Healthy Families</td>
<td>DC Healthcare Alliance</td>
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<td>---------------------------------------</td>
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</tr>
<tr>
<td>Acute elective (surgery)</td>
<td>Yes</td>
<td>Yes (Open Heart surgery, organ transplants and deliveries not covered)</td>
</tr>
<tr>
<td>Acute emergent / urgent</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Acute rehab</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigational</td>
<td>Yes</td>
<td>Not covered</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Subacute</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IV (Infusion) centers hospital based</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lithotripsy (hospital based)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional counseling-</td>
<td>Yes</td>
<td>Yes (weight loss services not covered)</td>
</tr>
<tr>
<td>HOME HEALTH ONLY (includes diabetes,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>obesity, HTN, etc.)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Nutritional counseling -</td>
<td>Yes</td>
<td>Yes (weight loss services not covered)</td>
</tr>
<tr>
<td>Hospital based</td>
<td></td>
<td></td>
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<tr>
<td>Observation</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Obstetric Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB Emergency Room</td>
<td>Yes</td>
<td>Not Covered</td>
</tr>
<tr>
<td>OB Monitoring- High Risk</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Orthotics (i.e., braces and splints)</td>
<td>Yes, &gt;$250/claim</td>
<td>Yes, &gt;$250/claim</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Out of Network Services</td>
<td>Yes</td>
<td>Not covered</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hyperbaric Treatment</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Yes, after 10 visits</td>
<td>Yes, after 10 visits</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Yes, after 10 visits</td>
<td>Yes, after 10 visits</td>
</tr>
<tr>
<td>Pulmonary Rehab</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>Yes, after 10 visits</td>
<td>Yes, after 10 visits</td>
</tr>
<tr>
<td>Whirlpool Treatment</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>TYPE OF SERVICE</td>
<td>DC Healthy Families</td>
<td>DC Healthcare Alliance</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
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<td>------------------------</td>
</tr>
<tr>
<td>(facility based)</td>
<td></td>
<td></td>
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<tr>
<td>Personal Care Services</td>
<td>Yes</td>
<td>Not covered</td>
</tr>
<tr>
<td>PET Scans</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pharmacy (IV/ IM)</td>
<td>Yes, if listed on the formulary as &quot;PA&quot;</td>
<td>Yes, if DC ADAP Pharmacy Provider Network is not utilized</td>
</tr>
<tr>
<td>Prosthetics (including foot orthotics and custom shoes)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Psych Testing / Neuropsych (medically related)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pulmonary Function Testing (Hospital based)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Sleep Studies</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Soft Supplies</td>
<td>Yes, if &gt;$350/month/member</td>
<td>Yes, if &gt;$350/month/member</td>
</tr>
<tr>
<td>Sonograms</td>
<td>Yes after 3 are performed in six months</td>
<td>Yes after 3 are performed in six months</td>
</tr>
<tr>
<td>Urgent/Emergent Procedures/Admissions -</td>
<td>(notification within 24-48 hours is required)</td>
<td>(notification within 24-48 hours is required)</td>
</tr>
<tr>
<td>Vision</td>
<td>Yes (inpatient facility)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Wound care</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Prior Authorization Notes:**

- Circumcisions (CPT 54150, 54160, and 54161) performed by a participating physician in a participating facility do not require prior-authorization.
- Breast biopsies (CPT 19100) performed by a participating physician in a participating facility do not require prior-authorization.
- Sweat chloride tests (CPT 89230) ordered by a participating provider at a participating facility do not require prior authorization.
- The participating high-risk OB physicians may perform 76801 through 76828 w/93325 at participating hospitals without an authorization.
- EGD’s (43235-43251 and 43255-43260) performed by a participating physician in a participating facility do not require prior-authorization.
- Colonoscopies (45378-45387 and 45391-45392) performed by a participating physician in a participating facility do not require prior-authorization.
- Sigmoidoscopies (45330-45342 and 45345) performed by a participating physician in a participating facility do not require prior-authorization.

**Injectibles and Non-Formulary Medications Requiring Prior-Authorization for DC Healthy Families**

Please refer to the MedStar Family Choice Formulary for a listing of medications that require prior-authorization. Be aware that high dollar injectibles, long-acting narcotics, and second-tier pharmacological agents require prior-authorization. MSFC Pharmacy protocols and MSFC formulary is available on the website. Written copies can be obtained upon request by calling the Provider Relations Department at (855) 210-6203.

**New Technology**

MedStar Family Choice evaluates new technology on an as needed basis. Providers may contact the MedStar Family Choice Care Management Department to request authorization for the new technology. The MedStar Family Choice Medical Director will review the request and make sure that it has been approved by the Food and Drug Administration. In addition, we will determine if the service is covered by the Medical Assistance and/or Alliance program. If it is covered under Medical Assistance or Alliance, the request will be approved if it is medically necessary. If Medical Assistance or Alliance does not currently cover the new technology MSFC will review industry standards in considering whether or not to cover the new technology.

I. **CLAIMS**

**Submitting Claims**

ICD-9/CPT/HCPCS codes in the medical record must match what is being requested for authorization and what is billed to MSFC. All services rendered to MSFC patients must be submitted within 180 days, in accordance with District of Columbia law. MedStar Family Choice will follow the billing guidelines outlined in the District of Columbia FFS program. Providers are required to submit claims using the same coding and format instructions as that required by the District Medicaid FFS programs. MedStar Family Choice accepts electronic submissions for both professional claims and institutional claims.

HIPAA compliant 837 files for **professional claims** through:
Institutional claims are accepted through:

- PayerPath (aka Allscripts)
- RelayHealth (aka McKesson)
- XactiMed (aka Medassets)
- Emdeon

Providers interested in using one of these clearinghouses, should contact the respective "Customer Service Office" and ask them how to enroll. Providers not using a clearinghouse, can submit both professional and institutional claims online. The MSFC website has more information regarding this process. Or, providers may contact the Claims Department at (800) 261-3371 for more information.

Paper claims should be sent to the following address:

MedStar Family Choice
Claims Processing Center
P.O. Box 2142
Milwaukee, WI  53201
Phone: (800) 261-3371 (Monday-Friday 8:00am-5:30pm)

Clean claims will be paid within 30 days, in accordance with District law. To inquire about claims status, please contact the MSFC claims department. Providers may also register to check claims status on-line by contacting the claims department.

Information regarding clean claims and fields required for clean claims can be found on the MSFC website. Providers may also contact the provider relations department for more information.

MSFC follows the CMS National Correct Coding Initiative when adjudicating claims.

Claims Appeal Process

Claims appeals should be sent to the address listed below within 90 business days of the denial. Please send a written request outlining reasons for appeal with all necessary documentation to the MedStar Family Choice Claims Processing Center. The appeal should also include a copy of the claim and the explanation of benefits. A provider appeal must include a clearly expressed desire for re-evaluation, with an indication as to why the denial was believed to have been issued incorrectly that MedStar Family Choice is able to investigate. For example, a situation in which MSFC receives only a Provider
Remittance Advice with items circled would not constitute a dispute and would be handled as a correspondence.

Providers will receive a response to their appeal within 30 calendar days. Second level appeals may be sent to the address listed above within 30 calendar days of the first level appeal response. The second level appeal is the final level of appeal. Providers will receive a response within 30 calendar days of the receipt of the second level appeal. An acknowledgement of receipt of the appeal (first and second level) will occur within five business days of receipt. All appeals should be sent to the following address:

MedStar Family Choice
901 D Street, SW
Suite 1050
Washington, DC  20024
Attn: Appeals Department

Claim denials that are overturned on appeal will be paid within 30 calendar days of the decision. MSFC will not take any punitive action against the provider for utilizing the provider appeal process.

**ER Auto-Pay List**

**DC Healthy Families**

The MSFC website contains the most up to date ER Auto-pay list. Claims for emergency services with ICD-9-CM diagnosis codes on the auto-pay list will be paid without further documentation. MSFC reserves the right to audit claims in accordance with District of Columbia regulations for consistency between clinical documentation and information presented on the bill (including the reported diagnosis). ER visits not included on the auto-pay list require medical documentation for payment. Providers may also obtain a copy of this auto-pay list by contacting the provider relations department.

**DC Healthcare Alliance**

The DHCF website contains the most up to date ER Auto-pay list for DC Healthcare Alliance claims. Emergency room claims that include a diagnosis on this list must be submitted to DHCF for payment. This would include emergency room visits that become inpatient admissions.

Professional payments for these services are submitted to MedStar Family Choice for review and payment.
**Overpayments- Refunds**

If a provider receives an overpayment for a claim, contact MedStar Family Choice Claims Department at 1-800-261-3371; then send the refund along with a copy of the EOB identifying the overpayment to the address below:

MedStar Family Choice
Claims Processing Center
P.O. Box 2142
Milwaukee, WI  53201

**Balance Billing of Members**

Providers may not bill members for the difference between the provider’s charge and MSFC’s payment for covered services. Providers cannot seek or accept additional or supplemental payment from the member, member’s family or representative, in addition to the amount by MSFC even when the member has signed an agreement to do so. These provisions also apply to out of network providers.
Section IV

Benefits and Services
A. OVERVIEW

- MedStar Family Choice must provide a complete and comprehensive benefit package that is equivalent to the benefits that are required by the District of Columbia for the DC Healthy Families and DC Healthcare Alliance programs.

- A MSFC 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. MSFC is responsible for reimbursing out-of-plan providers who have furnished these services to our members.

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

B. COVERED BENEFITS AND SERVICES FOR DC HEALTHY FAMILIES

Covered Benefits 21 years and over

All members should receive timely and effective care, in an appropriate health care system that meets the definition of Medically Necessary. For members 21 years and over, medically necessary is defined as a service a physician or other treating health provider, exercising prudent clinical judgment, would provide or order the service for a patient for the purpose of evaluating, diagnosing or treating illness, injury, disease, physical or mental health conditions, or their symptoms, and that is:

- In accordance with the generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury, disease, or physical or mental health condition; and
- Not primarily for the convenience of the individual or treating physician, or other treating health providers, and more cost effective than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results with respect to the diagnosis or treatment of that individual’s illness, injury, disease or physical or mental health condition.
The following is a summary of covered services, as defined by Federal Medicaid statute where it exists, provided to MSFC members enrolled in the DC Healthy Families program (other than mental health and alcohol and drug abuse services):

- Physician services
- Laboratory and X-ray services
- Inpatient hospital services (other than services in an institution for mental diseases)
- Outpatient hospital services
- Prescription drugs
- Emergency Services
  - Including on 24 hour-per day, 7 day-per-week basis triage to determine the existence of an Emergency Medical Condition, regardless of whether the triage is furnished on an inpatient or outpatient basis and regardless of whether the Provider furnishing triage services is a member of MSFC’s network, and stabilization services when a triage reveals the existence of an Emergency Medical Condition, regardless of whether the stabilization service is furnished on an inpatient or outpatient basis, and regardless of whether the Provider furnishing the stabilization service is a member of MSFC’s network.
- Federally Qualified Health Center (FQHC) services and any other ambulatory services offered by FQHC
- Family planning services and supplies furnished to individuals of child-bearing age including screening and immunization for the Human Papilloma Virus (HPV), and screening and preventive treatment for gonorrhea, regardless of whether the Provider furnishing the services and supplies is a member of MSFC’s Provider network.
- Pregnancy-related services
- Nurse Midwife services
- Nurse practitioner services furnished by pediatric nurse practitioners and family nurse practitioners.
- Podiatrists' services furnished by licensed podiatrists within the scope of practice under District of Columbia law.
- Physical therapy services
- Occupational therapy services
• Prosthetic devices.

• Eyeglasses, limited to one (1) complete pair in a twenty-four (24) month period except when a member has lost his or her eyeglasses or when the Member’s prescription has changed more than one-half (0.5) diopter.

• Tuberculosis-related services
  o For members determined to be infected with tuberculosis and whose condition is identified either by a MSFC's participating provider, or any other health care Provider examining the member. Such services consist of prescription drugs, physician services and hospital outpatient services, laboratory and x-ray services necessary to confirm the existence of infection, clinic services and FQHC services, case management services, and services (other than room and board) designed by the treating health professional or entity to encourage completion of treatment regimens by outpatients, including services to observe directly the intake of prescribed drugs.

• Home health services
• Private duty nursing services
• Personal care services.

• Nursing facility services for individuals age twenty-one (21) or older (other than services in an institution for mental diseases up to thirty (30) consecutive days.

• Hospice care described in Section 1905(o) of the Social Security Act

• Transportation services, including transportation related to the provision of triage and stabilization services for Emergency Medical Conditions.

• Adult wellness services, furnished in accordance with the scheduling and content recommendations of the United States Preventive Services Task Force, available at: http://www.ahrq.gov/clinic/pocketgd/gcpsl.htm, and consisting of the following items and services:
  o Women's wellness, consisting of an annual routine pelvic exam that includes screening and immunization for the Human Papilloma Virus (HPV) in accordance with recommendations of the Advisory Committee on Immunization Practices, as well as screening, and clinical preventive medicine for, gonorrhea;

• Immunizations recommended by the Advisory Committee on Immunization Practices;
• Routine screening for sexually transmitted diseases;
• HIV/AIDS screening, testing, and counseling;
• Breast cancer screening;
• Prostate cancer screening;
• Screening for obesity;
• Diabetes screening;
• Screening for high blood pressure and lipid disorders;
• Screening for depression;
• Tobacco cessation counseling;
• Diet and behavioral counseling;
• Osteoporosis screening in post-menopausal women;
• Alcohol misuse screening and behavioral counseling; and
• Aortic aneurysm screening.

• Dental services consisting of the following:
  • General dental examinations and routine maintenance cleaning with oral hygiene instruction limited to once every six (6) months;
  • Surgical services and extractions;
  • Emergency care;
  • Fillings;
  • Reline or rebase of a removable denture is limited to two (2) in five (5) years unless there is a prior authorization;
  • Complete radiographic survey, full series of X-rays or panoramic X-ray of the mouth is limited to once every three years. Additional complete radiographic survey, full series of X-rays or panoramic X-ray of the mouth requires prior authorization;
  • Full mouth debridement;
  • Prophylaxis limited to two times (2) per patient per year;
  • Bitewing series;
• Palliative treatment;
• Sealant application;
• Removable partial and full dentures;

Root canal treatment limited to two molars per year;
• Periodontal scaling and root planning, if:
  o Evidence of bone loss is present on current radiographs to support the
diagnosis of periodontist;
    ▪ There is a current periodontal charting with six point mobility
      noted, including the presence of pathology and periodontal
      prognosis;
    ▪ The pocket depths are greater than four millimeters; and
    ▪ Classification of the periodontology case type is in accordance with
documentation established by the American Academy of
      Periodontology.

• Removal of impacted teeth;

• Initial placement or replacement of a removable prosthesis (any dental device
  or appliance replacing one or more missing teeth, including associated
  structures, if required, that is designed to be removed and reinserted), once
  every five (5) years per member, unless the prosthesis:
    ▪ Was misplaced, stolen or damaged due to circumstances beyond
      the member's
    ▪ Cannot be modified or altered to meet the member's dental needs.

• A removable partial prosthesis is covered if:
  ▪ The crown to root ratio is better than 1: 1;
  ▪ The surrounding abutment teeth and the remaining teeth do not
    have extensive
  ▪ The abutment teeth do not have large restorations or stainless
    steel crowns.

  o Any dental service that requires inpatient hospitalization must be prior
    authorized by the State Agency; and;
    
    Elective surgical procedures requiring general anesthesia must be prior
    authorized by the State Agency.

The following shall not be covered:
  o Orthodontia
Hearing services, including diagnosis and treatment of conditions related to hearing, hearing aids and hearing aid batteries.

- Speech therapy

- Durable medical equipment

**Covered Services for Members under age twenty-one (21), including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services**

All members should receive timely and effective care, in an appropriate health care system that meets the definition of Medically Necessary. For members under 21 years, medically necessary is defined in the following manner:

- An EPSDT screening service
- An immunization recommend by the Advisory Committee on Immunization Practices
- A health care, diagnostic service, treatment, or other measure defined in federal regulations to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the District of Columbia State Medicaid plan.

In addition, medically necessary services and benefits will promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability. The healthcare intervention should:

- Assist in achieving, maintaining, or restoring health and functional capabilities without discrimination to the nature of a congenital/developmental abnormality
- Be appropriate for the age and developmental status of the child
- Take into account the setting that is appropriate to the specific needs of the child and family; and
- Be reasonably expected to produce the intended results for children and to have expected benefits that outweigh potential harmful effects.

The following is a summary of covered services, as defined by Federal Medicaid statute where it exists, provided to MSFC members enrolled in the DC Healthy Families program (other than mental health and alcohol and drug abuse services):

All EPSDT services will be covered and consist of the following:
**Screening and Assessment Services**

- Assessment of infant, child, and adolescent health and development, provided:
  
  o At intervals specified under the District of Columbia Health Check Periodicity Schedule
  
  o Upon request at times other than regularly scheduled periodic assessments, in order to determine the existence of a physical or mental condition; and

- Within 60 days of enrollment into MSFC's plan unless MSFC is able to secure written documentation from the child's medical record that the child is up-to-date in accordance with the periodicity schedule and that no separate request for an assessment has been received.

- Periodic assessments consisting of:
  
  - a comprehensive health and developmental history (including an assessment of both physical and mental health development);
  - an unclothed comprehensive health exam;
  - immunizations in accordance with recommendations of the ACIP;
  - laboratory tests including assessment of blood lead levels in accordance with District regulations
  - health education including anticipatory guidance;

- Dental screening services in accordance with the District of Columbia Dental Periodicity Schedule and at such other intervals as may be needed to identify the existence of a suspected illness or condition.

- Vision screening services in accordance with the District of Columbia Vision periodicity schedule and at such other intervals as may be needed to identify the existence of a suspected illness or condition.

- Hearing screening services in accordance with the District of Columbia Hearing periodicity schedule and at such other intervals as may be needed to identify the existence of a suspected illness or condition.

**Diagnostic and Treatment Services**

- Any benefit or service described in federal regulations or otherwise covered under the State Plan in the case of individuals ages 21 and older.

- Medically Necessary Case Management services
• Skilled nursing facility services for individuals under age twenty-one

• All Medically Necessary services described without regard to otherwise applicable limits on amount, duration and scope that might apply to individuals ages twenty-one (21) and older

• All services described in federal Medicaid regulations and outlined below:
  • Physician services
  • Laboratory and X-ray services
  • Inpatient hospital services (other than services in an institution for mental diseases)
  • Outpatient hospital services
  • Prescription drugs
  • Emergency Services
    o Including on 24 hour-per day, 7 day-per-week basis triage to determine the existence of an Emergency Medical Condition, regardless of whether the triage is furnished on an inpatient or outpatient basis and regardless of whether the Provider furnishing triage services is a member of MSFC’s network, and stabilization services when a triage reveals the existence of an Emergency Medical Condition, regardless of whether the stabilization service is furnished on an inpatient or outpatient basis, and regardless of whether the Provider furnishing the stabilization service is a member of MSFC’s network.
  • Federally Qualified Health Center (FQHC) services and any other ambulatory services offered by FQHC
  • Family planning services and supplies furnished to individuals of child-bearing age including screening and immunization for the Human Papilloma Virus (HPV), and screening and preventive treatment for gonorrhea, regardless of whether the Provider furnishing the services and supplies is a member of MSFC’s Provider network.
  • Pregnancy-related services
  • Nurse Midwife services
• Nurse practitioner services furnished by pediatric nurse practitioners and family nurse practitioners.

• Podiatrists' services furnished by licensed podiatrists within the scope of practice under District of Columbia law.

• Physical therapy services

• Occupational therapy services

• Prosthetic devices described

• Eyeglasses, limited to one (1) complete pair in a twenty-four (24) month period except when an Member has lost his or her eyeglasses or when the Member’s prescription has changed more than one-half (0.5) diopter.

• Tuberculosis-related services
  o For members determined to be infected with tuberculosis and whose condition is identified either by a member of MSFC's provider network, or any other health care Provider examining the Member. Such services consist of prescription drugs, physician services and hospital outpatient services, laboratory and x-ray services necessary to confirm the existence of infection, clinic services and FQHC services, case management services, and services (other than room and board) designed by the treating health professional or entity to encourage completion of treatment regimens by outpatients, including services to observe directly the intake of prescribed drugs.

• Home health services

• Private duty nursing services

• Personal care services.

• Nursing facility services for individuals under age twenty-one (21) (other than services in an institution for mental diseases up to thirty (30) consecutive days.

• Hospice care

• Transportation services, including transportation related to the provision of triage and stabilization services for Emergency Medical Conditions.

• Diagnosis and treatment of dental conditions, including dental services necessary to treat emergencies, relieve pain and infection, restore teeth, and maintain dental health (including Medically Necessary orthodontic
services and fluoride varnish performed by trained PCPs for Members under the age of three)

- Diagnosis and treatment of conditions related to vision, including corrective lenses as needed.

- Hearing services, including diagnosis and treatment of conditions related to hearing, hearing aids and hearing aid batteries.

- Speech therapy

- Durable medical equipment

- Inpatient hospital care for infants who are Boarder Babies and to whom the inpatient residential exclusion shall not apply and for whom no equally medically appropriate but less restrictive care setting can be located.

MSFC will not be responsible for coverage or payment of screening, diagnostic, and treatment services when such services are furnished to a Member in a school setting by a school program. MSFC shall be responsible for those items and services that are not provided in a school setting.

**Informing, scheduling, and transportation services**

Families and caregivers will be provided scheduling and transportation services necessary to ensure the timely receipt of assessments and the timely initiation of treatment. Transportation services consist of:

- Covered services outlined above

- EPSDT transportation services

- Health care related transportation services required by children who also are participating in educational programs, unless transportation is furnished directly by the public school system; and

- Health care related transportation services for Members under age 21 in foster care or out-of-home placements.
**Covered Behavioral Health Services**

MSFC will cover the following services:

- Care Coordination and Case Management for Members receiving the following services from DMH:
  - Community-Based Interventions;
  - Multi-Systemic Therapy (MST);
  - Assertive Community Treatment (ACT); and
  - Community Support.

- Services furnished by a network of mental health care Providers, including:
  - Diagnostic and Assessment Services;
  - Physician and mid-level visits, including:
    - Individual counseling;
    - Group counseling;
    - Family counseling; and
    - FQHC services.

- Medication/Somatic Treatment.

- Crisis services, including mobile crisis/emergency services provided by DMH, or Core Services Agencies certified by DMH to provide this service.

- Inpatient Hospitalization and Emergency Department services.

- Day Services.

- Intensive Day Treatment.

- Case management services, for individuals identified by the Department of Mental Health (DMH) as being chronically mentally ill or seriously emotionally disturbed.

- Inpatient psychiatric facility services for individuals under age 21

- Pregnancy-related services including treatment for any mental condition that could complicate the pregnancy.

- Patient Psychiatric Residential Treatment Facility services (PRTF) for individuals less than age 22 years.

- Education regarding how to access mental health services.
• All mental health services for children that are included in a JEP or IFSP during holidays, school vacations or sick days from school.

• Services provided to MCO-enrolled students in school settings to the extent that the following requirements are met:
  o The provider has a Sliding Fee Schedule for billing for children and youth without an IEP;
  o The Provider is credentialed as a network provider by the MSFC;
  o The Provider has an office in the school and provides services in that office; and
  o The Provider bills the MCO for the services using the codes provided by DHCF.

Special Rules Regarding Coverage of Services for Infants, Toddlers, Preschool-Age Children, and School-Age Children and Youth

MSFC shall cover all Medically Necessary services, for children under age twenty-one (21), regardless of whether the service in question is also identified as a "Related Service" under a child's education related treatment plan.

MSFC shall cover all transportation to and from Medically Necessary services, for children under age 21 regardless of whether the medical or health care service in question is also identified as a "Related Service" under a child’s education-related treatment plan employees or MSFCs.

MSFC is not responsible for otherwise Covered Services (including targeted and routine case management services) when the service is furnished in a school setting by the District of Columbia Public Schools (DCPS) employees or MSFCs. MSFC is not responsible for transportation services to or from covered services furnished in other than educational settings, when the transportation is furnished by DCPS or by MSFC.

Covered Services Not Covered by MSFC But Provided by the District of Columbia State Medicaid Plan

MedStar Family Choice is not responsible for the following categories of services that are covered under federal regulations but are not specifically mentioned in the sections above:

• Medical or other remedial care provided by licensed practitioners
• Diagnostic services
• Screening services
• Preventive services
• Rehabilitative services
• Mental health and substance abuse services
Clinic services

**Excluded Dental services for individuals age 21 and older**

- Local anesthetic that is used in conjunction with a surgical procedure and billed as a separate procedure;
- Hygiene aids, including toothbrushes;
- Medication dispensed by a dentist that a member is able to obtain from a pharmacy;
- Acid etch for a restoration that is billed as a separate procedure;
- Prosthesis cleaning;
- Removable unilateral partial denture that is a one-piece cast metal including clasps and teeth;
- Replacement of a denture when reline or rebase would correct the problem;
- Duplicative x-rays;
- Space maintainers
- Fixed prosthodontics (bridge), unless it is cost effective for a member who cannot use a removable prosthesis and prior authorization is required;
- Gold restoration, inlay or onlay, including cast nonprecious and semiprecious metals;
- Dental services for cosmetic or aesthetic purposes.

C. **COVERED SERVICES FOR DC HEALTHCARE ALLIANCE**

All members should receive timely and effective care, in an appropriate health care system that meets the definition of Medically Necessary. For members 21 years and over, medically necessary is defined as a service a physician or other treating health provider, exercising prudent clinical judgment, would provide or order the service for a patient for the purpose of evaluating, diagnosing or treating illness, injury, disease, physical or mental health conditions, or their symptoms, and that is:
• In accordance with the generally accepted standards of medical practice;
• Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, disease, or physical or mental health condition; and
• Not primarily for the convenience of the individual or treating physician, or other treating health providers, and more cost effective than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results with respect to the diagnosis or treatment of that individual's illness, injury, disease or physical or mental health condition.

The following is a summary of covered services, as defined by the District of Columbia provided to MSFC members enrolled in the DC Healthcare Alliance program:

• Primary and specialty physicians' services, and services and supplies incidental to physician services, when Medically Necessary to diagnose and treat illness, injury, and conditions. Services of specialists must be prior authorized by a patient's primary care physician.

• Inpatient and outpatient hospital services that are approved as medically necessary to diagnose and treat illness, injuries and conditions. Specific covered hospital services consist of the following:
  - Room and board (semi-private);
  - General nursing care;
  - Meals and special diets;
  - Special nursing care;
  - Anesthesiology (local and general);
  - Operating room;
  - Intensive care, cardiac care, trauma, and burns;
  - Surgical dressing including casts;
  - Laboratory services and other diagnostic tests;
  - Radiology services;
  - Specialty care and review and medical expert consultation; and
  - Other tests ordered by a network Provider.
  - Laboratory and x-ray services

• Adult wellness services, furnished in accordance with the scheduling and content recommendations of the United States Preventive Services Task Force (http://www.ahrq.gov/clinic/pocketgd/gcpsi.htm), and consisting of the following items and services:
  - Women's wellness, consisting of an annual routine pelvic exam that
includes screening and immunization for the Human Papilloma Virus (HPV) in accordance with recommendations of the Advisory Committee on Immunization Practices, as well as screening, and clinical preventive medicine for, gonorrhea;

- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP).
- Routine screening for sexually transmitted diseases;
- Family planning services and supplies (excluding infertility treatment), to protect against unintended pregnancies;
- HIV screening, testing, and counseling;
- Breast cancer screening;
- Prostate cancer screening;
- Screening for obesity;
- Diabetes screening;
- Screening for high blood pressure and lipid disorders;
- Screening for depression;
- Tobacco cessation counseling;
- Diet and behavioral counseling;
- Osteoporosis screening in post-menopausal women;
- Alcohol and drug screening
- Aortic aneurysm screening; and
- Each member shall receive at least one well primary care visit with a PCP on an annual basis.

- Pregnancy Care
  - Complete prenatal care
o Certified nurse Midwife services

o Appropriate treatment and follow-up care for miscarriage; and

o Postpartum services.

• Urgent care services

• Screening and stabilization of Emergency Medical Conditions when furnished by a healthcare Provider or hospital within the plan network.

• Outpatient prescription drugs not described in the formulary. For prescription drugs included in the formulary members shall be required to obtain such drugs at one of the Alliance program pharmacies.

• Rehabilitation services when pre-authorized as medically necessary

• Home health care services when pre-authorized for members who are determined to be homebound and consisting of the following services:
  
o Wound care;
  o Physical occupational and speech therapy;
  o Health education;
  o Home IV-therapy;
  o Routine visits to ascertain patient health status, check on the status of wounds, prescription drug monitoring; and
  o Home visits to assess readiness prior to discharge.

• Adult dental services for individuals ages twenty-one (21) and older, up to $1000 annually.

  o Dental exams every six (6) months;
  o Simple and complex surgical extractions;
  o Emergency care;
  o Fillings;
  o Cleaning and fluoride treatments every six (6) months;
  o Space maintainers (partial dentures) when Medically Necessary;
  o X-rays;
  o Dentures (one new set every five (5) years) and denture repair; and
  o Oral surgery

• Emergency transportation services

• Physical therapy, occupational therapy, and speech therapy
• Dialysis services

**Coverage Exclusions under the Alliance Program**

• Screening and stabilization services for Emergency Medical Conditions, provided outside the District;

• Covered services provided outside of the District of Columbia

• Services furnished in schools;

• Any Covered Services when furnished by Providers that are not members of MSFC’s Network;

• Services and supplies related to surgery and treatment for temporal mandibular joint problems (TMJ);

• Chiropractic services;

• Cosmetic surgery

• Open heart surgery;

• Organ transplantation;

• Sclerotherapy;

• Therapeutic abortions;

• Vision care for adults

• Treatment for obesity;

• Infertility treatment;

• Experimental Treatment and investigational services

• Treatment for mental health, behavioral health and alcohol or substance abuse services, except services related to medical treatment received in a hospital for life threatening withdrawal from alcohol or narcotic drugs;
• Deliveries

• Non-emergency transportation services; and

• Mental health and substance abuse services.

D. COVERAGE OF INPATIENT SERVICES AT THE TIME OF ENROLLMENT

MSFC shall not be responsible for the payment of claims for Covered Services provided during a hospital stay if the date of admission precedes the date of Member's enrollment with MSFC.

E. EXCLUDED SERVICES

The following items and services are excluded from coverage. MSFC shall not provide items and services that are excluded from coverage. MSFC shall exclude a service from coverage or deny payment for a service only under the circumstances expressly described below.

• The services are not described in previous sections.
• The service is of an amount, duration and scope in excess of a limit covered by the applicable healthcare program (DC Healthy Families or DC Healthcare Alliance).
• The service is not medically necessary.
• The service is a prescription drug that DHCF permits MSFC to exclude from the formulary.
• The service is inpatient transplantation surgery or a service provided during the inpatient stay in which the transplant surgery takes place and MSFC has obtained written authorization from DHCF in advance of the member's admission for the surgery that the surgery or related service is not the financial responsibility of MSFC. MSFC will cover costs up to the time of the transplant surgery and shall be responsible for the costs after discharge from the hospital stay during which the transplant surgery occurred. MSFC is not responsible for transplant surgery.

• The provider is responsible for notifying MSFC in advance if a transplant is recommended. The provider and MSFC will collaborate to secure approval from DCHF for the transplant surgery. DHCF is responsible for payment for transplant services. If the provider fails to secure approval from DHCF, MSFC will not reimburse the provider for services which would have been paid by DHCF had the provider secured approval from DHCF for the transplant surgery.
The service is cosmetic, except that the following services shall not be considered cosmetic:
  - Surgery required to correct a condition resulting from surgery or disease;
  - Surgery required to correct a condition created by an accidental injury;
  - Surgery required to correct a congenital deformity; or
  - Surgery required to correct a condition that impairs the normal function of a part of the body.

The service is a sterilization procedure for a member under age twenty-one (21).

The service is an abortion that does not meet the standard of the applicable Appropriations Act for the District of Columbia. The limitations shall not apply to an abortion in the following circumstances:
  - If the pregnancy is the result of an act of rape or incest; or
  - In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

The service is investigational or an Experimental Treatment(s). A service is an investigational or Experimental Treatment if it is a diagnostic or treatment service that, in accordance with relevant evidence, are not considered to fall within the range of professionally accepted clinical practice with respect to illness, disability, or condition that is the focus of a coverage determination.

The services are part of a clinical trial protocol. MSFC shall cover all inpatient and outpatient services furnished over the course of a clinical trial, but shall not cover the services included in the clinical trial protocol.

F. HEALTH CARE ACQUIRED CONDITIONS (HCAC)

MSFC will not reimburse providers for procedures relating to the following Health Care Acquired Conditions (HCAC), identified in the Affordable Care Act of 2010, Public Law 111-148, when any of the following conditions are not present upon admission in any inpatient setting, but subsequently acquired in that setting:
  - Foreign Object Retained after Surgery
  - Air Embolism
  - Blood Incompatibility
  - Catheter Associated Urinary Tract Infection
  - Pressure Ulcers (Decubitus Ulcers)
  - Vascular Catheter Associated Infection
Mediastinitis after Coronary Artery Bypass Graft (CABG)
Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, bum and other unspecified effects of external causes
Manifestations of Poor Glycemic Control
Surgical Site Infection following Certain Orthopedic Procedures
Surgical Site Infection following Bariatric Surgery for Obesity and
Deep Vein Thrombosis and Pulmonary Embolism following Certain
Orthopedic Procedures except for Pediatric (individuals under the age of 21 years) and
Obstetric Populations

G. NEVER EVENTS

MSFC will not reimburse for any of the following Never Events in any inpatient or outpatient setting:
  - Surgery performed on the Wrong Body Part;
  - Surgery performed on the Wrong Patient; and
  - Wrong surgical procedure performed on a Patient
Section V

DHCF Quality Improvement and MSFC Oversight Activities
A. QUALITY IMPROVEMENT PROGRAM

MedStar Family Choice has a history of delivering quality care to its members. In order to maintain and continually improve the quality of care it delivers, MSFC has created a comprehensive Quality Improvement (QI) program.

MSFC has a Quality Improvement / Utilization Management (QI/UM) Committee that meets on a regular basis to review and update quality management policies and initiatives. It is chaired by the Medical Director and comprised of qualified medical professionals and MSFC staff.

A Quality Improvement Plan (QI Plan) is developed annually and reviewed/updated monthly to ensure MSFC is meeting its quality goals and objectives to improve performance, health outcomes, reduce disparities in utilization and outcomes. Updates to this plan are sent routinely to the District of Columbia Department of Health Care Finance. The QI Plan addresses issues such as:

- Performance improvement strategies and quality improvement activities with specific time lines, methodology, benchmarks and evaluation criteria;
- Performance measures that analyze the effectiveness of service delivery, quality of care, case management and care coordination;
- Systematic collection and interpretation of data concerning performance and member outcomes;
- Processes for utilizing data to drive necessary changes to MSFC’s operations, policies and procedures.
- Opportunities for appropriate health professionals to review procedures and processes for providing health services; and
- General Clinical Initiatives that address specific clinical areas such as childhood immunizations, hypertension, diabetes, and health disparities.

To monitor, evaluate, and improve its quality performance, MSFC will utilize a number of performance measurement tools including, but not limited to:

- The Healthcare Effectiveness Data and Information Set (HEDIS) survey. HEDIS is a set of standardized performance measures designed by the National Committee for Quality Assurance. The measures are audited by an independent entity and are reported to DHCF;
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey which measures member satisfaction with the health plan and providers;
- Provider satisfaction survey which measures the providers’ satisfaction with the health plan;
- Available results of the External Quality Review Organization (EQRO). The EQRO is a review of MSFC’s quality improvement processes and clinical care. The audit assesses the structure, process and outcome of MSFC’s internal quality program; and
- The DC Collaborative Perinatal Risk Screening tool (prenatal care providers only).
MSFC delegates further quality improvement functions to vision, pharmacy, behavioral health, dental and transportation providers. Each delegated entity will be required to submit a Quality Improvement Plan, Utilization management Plan, Work Plan, and annual QI/UM Appraisals. A designated QI Coordinator and individual Oversight Committees maintain communication between MSFC and each delegated entity.

**Provider Role in Quality Management**

In order to fully carry out its Quality Improvement functions, MSFC asks for and appreciates cooperation from participating providers on a number of Quality Improvement initiatives. These initiatives include, but are not limited to:

1. **Provider Satisfaction Surveys.** At least once a year, MSFC will utilize a nationally recognized and validated tool to measure satisfaction among its network providers. This survey will address concerns of importance to providers in treating Members.

2. **Provider Performance Measurement.** In order to ensure quality care for our Members, MSFC continually measures the performance of providers based on accepted clinical practice standards in areas such as quality of care, access standards, and use of treatment guidelines. MSFC will recommend appropriate action to correct any identified deficiencies and provide performance feedback to providers on a quarterly basis.

3. **Medical Record Audits.** In order to collect data on performance and quality of care, MSFC may perform chart audits. MSFC asks for provider cooperation with data requested by the EQRO for quality improvement purposes.

4. **Participation in Peer Review.** All quality issues related to clinical care will be referred to MSFC’s Peer Review Committee, which meets quarterly to discuss all referred cases. The Peer Review Committee will take appropriate action which may include requesting further information, closing the case, or recommending further corrective action.

5. **External Auditing and Monitoring.** MSFC asks for provider cooperation with DHCF’s EQRO in its review and auditing activities. Activities relevant for providers may include, but are not limited to: on-site visits, staff and Member interviews, medical record reviews, and review of staff and provider qualifications.

**Medical Record Requirements**

Providers must retain medical records in accordance with the Provider Agreement and District of Columbia law. MedStar Family Choice also has recommended medical record documentation standards. A complete listing of the documentation requirements can be found on the MSFC website at www.medstarfamilychoice.com. A copy can also be obtained from our Provider Relations Department by calling (855) 210-6203. Documentation requirements specifically include discussions with the member regarding
Advanced Directives. Providers are required to discuss Advance Directives with members, educate them on how to create an Advanced Directive and document those conversations.

**Additional Information**

Additional information regarding the MSFC QI can be found on our website. You may also request this information in writing by calling Provider Relations at (855) 210-6203.

**Critical Incidents, Sentinel Events, and Never Events**

A **Critical Incident** is defined as a quality of care issue that has caused serious harm or injury. A **Sentinel Event** is an unexpected occurrence that has caused a participant death or serious physical or psychological injury that includes permanent loss of function. All Critical Incidents and Sentinel Events must be reported immediately to the Care Management Department of MSFC at (855) 210-6203. MSFC will report them to DHCF’s Administrator for Quality Management and Program Integrity within 24 hours of their occurrence. Critical Incidents and Sentinel Events will be reviewed by a designated multi-disciplinary committee under the leadership of the Medical Director, which will issue protocols and order corrective actions as needed.

**Never Events and Health Care Acquired Conditions**

A **Never Event** is an adverse event that is serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. A **Health-Care Acquired Condition** is a condition that arose during a stay in a hospital or medical facility, and is defined by the Affordable Care Act as “a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Act.” Providers shall not receive reimbursement for any Never Event or Health-Care Acquired Condition that occurs in any inpatient or outpatient setting.

**B. MSFC COMPLIANCE PROGRAM**

**Fraud, Waste and Abuse**

MedStar Family Choice and MedStar Health have comprehensive Compliance programs in place to monitor and detect fraud and abuse. Fraud and abuse could be committed by a provider, member, or even an employee of the MCO. As a MedStar Family Choice provider, it is a provider’s responsibility to report fraud, waste, or abuse.
Medicaid defines fraud as an intentional deception made by a person or company with the intent to gain some unauthorized benefit from the deception. Medicaid defines abuse as practices that do not follow sound financial, business or medical practice and result in unnecessary costs or do not meet a standard of care.

Providers must report suspected fraud and abuse. Some common examples of fraud and abuse are:

- Billing for a service that was never performed
- Unbundling of procedures
- Upcoding
- Performing unnecessary procedures
- Altering or forging a prescription
- Selling prescriptions
- Underreporting financial information in order to qualify for benefits
- Supplying false information when applying for benefits
- Allowing others to use a member's ID card for care

Most billing errors are oversights and not indicators of fraudulent activity. However, fraud and abuse does occur and DHCF has tasked MedStar Family Choice with monitoring, identifying, and deterring these types of activities. As a result, MedStar Family Choice has created a comprehensive Fraud, Abuse, and Waste Compliance Program (“Compliance Program”), overseen by the Compliance Director. The Compliance Program includes:

- A Compliance Plan that articulates policies, procedures, and standards of conduct that complies with all federal and District standards;
- Regular monitoring and auditing of claims submissions and encounter data;
- Routine and random chart audits which providers are subject to comply with;
- Compliance training for officers, directors, managers and employees regarding the provisions of the Compliance Plan; and
- Procedures for prompt reporting of suspected fraud, abuse, and waste information to the District of Columbia.

When someone is reported for possible fraud and abuse, MedStar Family Choice will perform an investigation and the results will be reported to the Department of HealthCare Finance, or other District agencies as appropriate. The District agency may perform its own investigation as well. Individuals found to have committed fraud or abuse may be subjected to penalties such as but not limited to loss the health benefits, termination of contract, fines or imprisonment.

If overpayments related to fraudulent or abusive billing has been identified, MedStar Family Choice may retract payments made to providers. In addition, MSFC may be required to notify the DHCF and/or other District of Columbia agencies of the retraction.
Providers will be notified of the retraction. The notification will include the following:

1. The reason for retractions of payments
2. The amount to be retracted
3. A list of claims that will be retracted
4. Notification of the providers right to appeal

Providers will have ninety (90) business days to appeal. The appeal must be submitted to in writing and to the following address:

MedStar Family Choice  
901 D St SW  
Suite 1050  
Washington, DC 20024  
Attn: Claims Appeals

If additional documentation is available to support the reversal of the denied services, these should be submitted at this time. MSFC will send a written acknowledgement to the provider of receipt of the appeal within 5 business days. MSFC will notify the provider of the determination of the appeal, in writing, within 30 calendar days of the receipt of appeal. Should the provider remain dissatisfied with the decision issued, the provider may submit a request for reconsideration to the President, MedStar Family Choice or his/ her designee. A written request must be filed within 30 calendar days of MSFC’s notice of decision of the first level of appeal. MSFC will send a written acknowledgement to the provider of receipt of the appeal with 5 business days. A decision will be rendered within 30 calendar days of the request. Should the provider remain dissatisfied with the decision issued, the terms in the Provider’s Agreement, regarding Dispute Resolution, shall apply.

**Exclusion Lists**

MSFC is prohibited from paying for items or services furnished by a provider or organization that has been excluded from the Medicaid program. MSFC monitors the appropriate exclusion lists on a routine basis. Providers are responsible for monitoring the Medicaid exclusion list and the HHS-OIG website to determine if any employees or MSFCs are on this list. For more information regarding how to access the exclusion lists, providers should refer EPLS’s website.

In addition to the Compliance Program described above, it is important that MSFC providers understand the False Claims Act provisions for Federal and state governments. Under the Deficit Reduction Act of 2005, entities receiving $5 million or more in Medicaid funding must educate employees, MSFCs and agents about Federal and State fraud and false claims laws, as well as whistle blower protections. More
information on the Federal False Claims act and the District of Columbia False Claims Act can be found on the MSFC website or by contacting the MSFC provider relations department.

While MedStar Family Choice monitors for possible fraud and abuse activities, MSFC asks its providers help to eliminate fraud and abuse. **Providers suspecting fraud and abuse must report this immediately by calling the MedStar Family Choice Compliance Director or Provider Relations at (855) 210-6203.** Providers may remain anonymous and all reports will be kept confidential. In addition, MedStar Family Choice enforces a non-retaliation policy for those individuals reporting possible fraud and abuse activities. Providers may also notify the Department of Health Care Finance at (877) 632-2873. Or providers may report it in writing at 899 N. Capitol Street, NW, Washington, DC 20002. Reports will be kept confidential.

**HIPAA**

MedStar Family Choice provides all new members a copy of its Notice of Privacy Practices upon joining MedStar Family Choice. A copy of the notice is also available on our website at [www.medstarfamilychoice.com](http://www.medstarfamilychoice.com). Provider Relations can provide copies of this notice upon request. The Notice outlines how MSFC may use and disclose our member's information and when authorization for use and disclosure is required.

MedStar Family Choice has appropriate policies and procedures in place to make sure that our member's protected health information is safeguarded. These policies explain how MSFC protects verbal, and written, electronic protected health information (including mobile devices).

To ensure the privacy and security of its Members’ medical information, MSFC requires its providers to abide by a number of medical record documentation standards. These standards include provisions such as:

- Providing a Notice of Privacy Practices to members
- Compliance with all federal, state and local regulations pertaining to medical records;
- Secure storage of both paper and electronic medical records;
- Standards to ensure confidentiality of Member information;
- Release of information only to authorized staff, including those from DHCF, DOH, and HHS for quality assurance and auditing purposes; and
- Reporting to MSFC in a timeframe required by law, breaches of the HIPAA privacy rules as it relates to MSFC members and cooperate with MSFC in the remediation of such breaches.

**Providers must report privacy breaches related to MSFC members immediately in accordance with the Provider Agreement.** Providers suspecting fraud and abuse must report this immediately by calling the MedStar Family Choice
C. GRIEVANCES AND APPEALS REPORTING

MSFC is responsible for gathering and reporting regularly to the District information about member’s appeals and grievances and our interventions and resolution to these appeals and grievances. To accomplish this, MSFC is required to operate a Consumer Services Hotline and Internal grievance process.

MedStar Family Choice Member Hotline

MedStar Family Choice maintains a member services unit that operates a Member Services Department which is available Monday-Friday 8:00am-5:30pm. Calls or faxes received after hours will be addressed the next business day. This unit handles and resolves or properly refers members' inquiries or complaints to the appropriate individuals within MSFC. MSFC establishes goals for average speed of answer (less than 20 seconds) and call abandonment rate for member services lines for MSFC and for the delegated vendors who field member services calls.

MedStar Family Choice Member Grievance/Appeal Policy and Procedures

MedStar Family Choice has written grievance policies and procedures whereby a member who is dissatisfied with the MCO or its network may seek recourse verbally or in writing from the MSFC Member Services Department.

MedStar Family Choice’s internal grievance materials are developed in a culturally sensitive manner, at a suitable reading comprehension level, and in the member’s native tongue if the member is a member of a substantial minority. MedStar Family Choice delivers a copy of its grievance and appeal policies and procedures to each new member at the time of initial enrollment, and at any time upon a member's request.

Any of the following may file a Grievance or Appeal:
1. The Member affected by the determination;
2. If the Member is a minor child, the Member’s parent, guardian or authorized representative;
3. In the case of a Grievance, an authorized representative, including but not limited to, an Attorney, a MSFC staff member, or other non-legal advocate, acting on behalf of the Member; and
4. In the case of an Appeal, an authorized representative, or a Provider acting on behalf of the Member and with the Member’s written consent.
No punitive action will be taken against the member for making a grievance or appeal against MSFC.

**Member Complaint/Grievance Procedure**

If members have a question or grievance about their health care, such as not being able to schedule an appointment, the way in which they were treated or having to travel too far to get health care services, they should call Member Services toll-free at 1-888-404-3549 Monday-Friday between 8:00 am and 5:30pm. The member service representative will:

1. Take the grievance
2. Answer any questions
3. Tell the member when he/she will have an answer MSFC has up to 30 days to provide a response to the grievance. MSFC may ask for additional time (up to an additional 14 days) to resolve the grievance if requested by the member, provider or if MSFC can show that additional time would be beneficial to the member. 
4. Provide written acknowledgement of the receipt of the Grievance within two (2) business days of receipt.
5. Forward the grievance to the appropriate person, who will: 
   a. Investigate the grievance
   b. Decide what steps will be taken
   c. Respond to the grievance
6. If the member is not satisfied with the resolution of the complaint/grievance he/she may request a fair hearing.

**Medical Coverage Appeal Process for Members**

MedStar Family Choice approves or denies services based upon whether or not the service is medically necessary and is a covered benefit. MSFC does not financially reward MSFC providers, staff or anyone contracted with MedStar Family Choice for denying services. In addition, MSFC does not financially reward anyone involved in the decision process in such a way that would encourage them to deny services.

When the member does not agree with MSFC’s decision to deny, stop or reduce a service that has been requested by a provider, the member can ask MSFC to review our decision again. Members may appeal MedStar Family Choice’s decision to cover a service once they receive a denial (adverse determination) letter from MSFC. Members or their authorized representative have 90 days after receiving a denial to appeal a decision. The letter provides the details of why the medical services were denied. It also
gives instructions on the appeals process. They can provide the member with information on how to request a hearing.

Medical appeals are either urgent or non-urgent. Appeals are considered to be urgent if the member’s life is in jeopardy, if there could be a loss in the ability to regain maximum functioning or if the doctor believes the care is urgent or could cause the member severe pain.

The appeal, verbal or written, must include the specific reason for reconsidering the denial. The member may file the appeal on his/her own. MSFC has a simple form members can use to file their appeal. Members can obtain this form by calling (855) 210-6203. MSFC will mail or fax the appeal form to the member and provide assistance in completing it if necessary. Other people can also help them file an appeal, like a family member or a lawyer. With written permission from the member, members may have their provider or an authorized representative file the appeal on their behalf. A form is available on our website that permits providers to appeal on behalf of members. However, an appeal will not be processed until a signed form has been received from the member stating the provider may appeal on the member’s behalf.

All requests for appeals can be submitted verbally or in writing to the MedStar Family Choice Denial and Appeal Division. Written appeals must be sent to the following address:

MedStar Family Choice  
901 D Street SW  
Suite 1050  
Washington, DC 20024  
Attn: Denial and Appeal Division

Verbal requests for appeals can be obtained by calling (855) 210-6203 Monday through Friday between 8:00 am and 5:30 pm. MSFC will send a letter to the member acknowledging receipt of the appeal within two business days. When an appeal is filed, MSFC should be notified of any new information that will help MSFC make a decision. While the appeal is being reviewed, MSFC can still receive any additional information that the provider thinks will help MSFC make a decision.

When reviewing the appeal MSFC will:
• Use doctors who know about the type of illness.
• Not use the same people who denied the request for a service.
• Make a decision about the appeal within 3 days for urgent appeals and 15 days for standard pre-service appeals. Decisions for post-service appeals will be made within 30 calendar days of the receipt of the request.
• MSFC may extend the timeframe up to 5 days if requested by the member, or if MSFC can show that an extension would benefit the member. If MSFC denies a request for an expedited appeal, MSFC will process the appeal within the standard
appeal timeframe and make reasonable efforts to promptly alert the member of the
denial orally and follow-up with a written notice within two (2) days.

MSFC will notify providers and members of the decision within the following
timeframes:

- Expedited Appeals: Verbal notification via telephone will be sent to the provider on
the same day as the decision. In the case of expedited appeals, MSFC will make
reasonable efforts to provide oral notice of the decision to the member. Written
notification will be sent to the provider and member within 2 calendar days of the
decision.
- Standard Pre-service appeals: Written notification will be sent to the provider and
the member within 2 calendar days of the decision.
Post-service appeals: Written notification will be sent to the provider and the member
within 2 calendar days of the decision and within 30 calendar days of the request.

Written notice of the appeal resolution will include the results and date of the Appeal
resolution, the Member’s right to request a District Fair Hearing and how to do so, the
Member’s right to receive benefits while the Fair Hearing is pending, and how the
member can assure his or her benefits are continued.

**District Fair Hearings**

At any point before, during or after the Appeal process, the Member who is the subject
of an Action may request a District Fair Hearing. MSFC will provide each Member with
information about their right to request a Fair Hearing, the method by which they may
obtain a Fair Hearing, and their right to represent themselves or to be represented by
their family caregiver, legal counsel or other representative. Within 5 days of receiving
notice from DHCF that a Fair Hearing request has been filed, MSFC will submit all
documents regarding the Action and the Member’s dispute to DHCF. The District Office
of Administrative Hearings will issue a decision within 90 days of the date the Member
filed the appeal for standard resolution or within 3 working days for expedited
resolution. The District’s decision will be final and cannot be appealed by the MSFC.

While the Appeal or District Fair Hearing is pending, the Member is entitled to have
his/her benefits continued if the following requirements are met:

1. The Member filed an Appeal or requested a Fair Hearing on or before ten (10)
days of the date on the Notice of Action or on the intended effective date of the
proposed action;
2. The Appeal or Fair Hearing involves the termination, suspension or reduction of a
course of treatment previously authorized by an authorized provider; and
3. The authorization period has not expired.
If an Appeal or Fair Hearing results in a reversal of a decision to deny, limit or delay services that were not furnished while the Appeal was pending, MSFC will authorize or provide the disputed services as expeditiously as the Member’s health condition requires and no later than 2 business days after the reversal of the decision for standard appeals and services shall begin within 24 hours of the reversal for expedited appeals.

**MedStar Family Choice Provider Grievance/Appeal Process**

The following process applies when the provider dispute is regarding Adverse Determinations on their own behalf and NOT on behalf of members.

1. Providers acting on their own behalf are defined as those who dispute Adverse Determinations when the service has already been provided to the member and there is NO member financial liability and members who are in acute inpatient care where there is no discharge order written.

2. A provider dispute must include a clearly expressed desire for re-evaluation, with an indication as to why the Adverse Determination was believed to have been issued incorrectly that MedStar Family Choice is able to investigate. For example, a situation in which MSFC receives only a Provider Remittance Advice with items circled would not constitute a dispute and would be handled as a correspondence.

Providers requesting appeals of medical coverage on behalf of members (with the members’ written permission) are subject to the MSFC policy entitled “Member Appeals” and should reference the section “Medical Coverage Appeal Process for Members” in this manual for timeframes and additional information.

MedStar Family Choice has a formal dispute process that is compliant with the standards and regulations set forth by DHCF, as applicable, and NCQA. These standards and regulations serve as guidelines to ensure that:

- Dispute review turnaround time requirements are met.
- Appropriately qualified professionals are involved in the review of provider disputes.
- Relevant clinical and administrative information is consistently gathered and reviewed as part of the dispute investigation.
- Providers are informed of the rationale for disputes that are upheld, in whole or in part.
- Providers are informed of the right to initiate the next level of the dispute process, when applicable.

MSFC will not take any punitive action for providers utilizing the grievance/appeal process.

Provider disputes are categorized in three ways:
1. Based on whether the dispute is to be processed clinically or administratively.
2. Based on whether the dispute is at the First-Level or Second-Level.
3. Based on whether the dispute is considered urgent or non-urgent.

A. Clinical Dispute Reviews & Administrative Dispute Reviews
   1. For both clinical and administrative disputes, the reviewer is not to have been
      involved in the initial Adverse Determination and is not to be a subordinate of
      any person involved in the initial Adverse Determination.
   2. The following situations are handled entirely through an administrative
      process. See Chapter 3 for submission timeframes and appeals address
      information.
      a. Lack of prior authorization when there is no allegation of an emergent
         circumstance that would have precluded obtaining prior authorization (all
         levels of care except inpatient).
      b. Benefit claims determinations including, but not limited to, issues related
         to timely filing, COB, etc.
   3. Some administrative disputes require that there be a clinical review by an
      appropriate clinical reviewer to determine whether there are clinical reasons
      that prevent making a decision based strictly on administrative reasons. The
      following situations are to be reviewed clinically prior to being processed
      administratively:
      a. Inpatient lack of prior authorization, to determine whether an emergency
         or other clinical situation existed at the time of the admission that
         precluded the member or facility from obtaining pre-authorization.
   4. Insufficient information. The provider dispute information listed in this
      Section refers to clinical disputes only. Clinical disputes should be sent to the
      following location:

      MedStar Family Choice
      901 D Street, SW
      Suite 1050
      Washington, DC 20024
      Fax: (202) 243-5496

B. First-Level Provider Disputes
   1. Urgent Dispute Process (Expedited)
      a. Urgent disputes can be requested up to 90 business days from the date of
         the Adverse Determination letter (denial) during the hospitalization when
         member liability is not involved.
      b. An urgent dispute may be requested verbally (855) 210-6203 in writing.
      c. Urgent disputes are accepted in cases where the application of non-urgent
         procedures and timeframes could seriously jeopardize the member’s life,
         health or ability to regain maximum functioning, or if, in the opinion of the
treating clinician, the care requested is urgent or, if not provided, would cause the member severe pain.

d. The urgent dispute review process begins at the time MSFC receives the dispute request.

e. MSFC will provide an acknowledgement of the appeal within 5 business days of receipt.

f. The provider is offered an opportunity to submit any written comments, documentation, or records for consideration during the appeal process. In situations where MSFC deems there is insufficient information to make a determination, only the minimum necessary information to provide a complete review of the dispute is to be requested.

g. The appeals staff may arrange a time for the treating clinician to telephonically review the case with the Appeal Reviewer.

h. MSFC conducts a review of the dispute in a manner that does not give deference to the Adverse Determination decision. MSFC investigates the content of the appeal, including any and all aspects of clinical care involved, and documents its findings.

i. Within three (3) days of receiving a request for an urgent dispute, MSFC makes a determination and notifies the provider by telephone. Written notification of the dispute outcome is sent to the provider, facility and PCP within one calendar day of the decision. In making urgent determinations, MSFC considers the seriousness of the member’s condition.

j. If the treating clinician fails to telephone the Appeal Reviewer for the urgent dispute review, the Appeal Reviewer makes a reasonable effort to contact the treating clinician prior to making a determination. If the Appeal Reviewer is unsuccessful in reaching the treating clinician, the Appeal Reviewer makes an urgent appeal determination based on the available information.

k. If the previous Adverse Determination is overturned, the dispute reviewer or designee notifies the provider by telephone of the outcome and transmits the written appeal notification to the provider, facility and PCP.

l. If the Adverse Determination is upheld, the Appeal Reviewer or designee notifies the provider by telephone of the outcome and offers additional appeal options. An appeals staff person coordinates the overall process and transmits the written appeal notification to the provider, facility and PCP.

2. Non-urgent Dispute Process (Standard)
   a. Non-urgent disputes must be requested within 90 business days from the date of the adverse determination letter.
   b. Non-urgent provider dispute requests must be submitted in writing.
   c. MSFC will provide acknowledgement of the appeal within 5 business days of receipt.
d. The provider is offered the opportunity to submit any written comments, documentation, or records for consideration during the dispute process.

e. Provider disputes must be accompanied by a complete copy of the member’s pertinent medical record. If more information is needed to make a decision, MSFC will assist in the procurement of this information.

f. MSFC makes the First-level non-urgent provider dispute determination and notifies the provider in writing within 30 calendar days of the receipt of the First-level non-urgent provider dispute request.

g. MSFC conducts a review of the dispute that does not give deference to the initial Adverse Determination. For clinical disputes, MSFC investigates the content of the dispute, including all aspects of clinical care involved, and documents its findings.

h. In the event that the dispute is overturned, an appropriate authorization is entered into the member’s electronic record and a written authorization letter is generated. Notice is provided to the claims department to ensure payment of the authorized days / visits. Payment will be made within 30 calendar days from the date of the determination. Appeals staff also transmits a written dispute notification to the appellant, facility, attending provider and PCP.

i. In the event that the dispute is upheld, appeals staff transmits the written dispute notification to the appellant, facility, attending provider and PCP.

C. Second-level Provider Disputes

1. If a provider or authorized provider representative is dissatisfied with the First-level dispute review determination, a Second-level dispute review may be requested.

2. When processing Second-level provider dispute requests, MSFC follows the process for First-level provider disputes as outlined in Section B of this policy, with the following exceptions.

a. The request for a Second-level dispute must be received by MSFC within 30 calendar days from the date of the First-level dispute notification letter.