Section III

MedStar Family Choice
Care Management and Claims

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. The Outreach Department can also authorize and arrange transportation for members that meet certain medical criteria. The Utilization Management staff will review pre-authorization requests. 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 8:30am-5pm at (410) 933-2200, (800) 905-1722 or fax (410) 933-2274 or (888) 243-1790. Telephone calls 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.

OUTREACH SERVICES

The Outreach Department is available Monday-Friday 8:30am-5pm. MSFC can be reached at (800) 905-1722 or (410) 933-2200. Providers may also fax MSFC at (410) 933-2232 or (888) 991-2232. Voice messages and faxes received after hours will be handled the next business day.

Initial Health Assessments

All new members are required by State regulation to have an initial health assessment upon joining MedStar Family Choice, unless the member has recently received an exam by the PCP prior to enrolling into MSFC and the provider concludes that no immediate appointment is necessary. Otherwise, initial health assessments must occur within 90 days of enrollment. Exceptions to this are children under 21 years where EPSDT timeframes vary based on a periodicity schedule. In addition, pregnant and post-partum women not in care must be seen within 10 days of request. Lastly, those with a positive health risk assessment must be seen within 15 days. New members will be contacted via telephone and letter reminding them of the need to schedule these appointments. In many instances, MSFC Outreach will perform a three-way call between the MSFC outreach representative, 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 in required outreach attempts for preventive care and member non-compliance. If providers are aware of non-compliant members, as defined in Chapter 2 of this manual, providers may contact the Outreach Department. The Outreach Department performs Outreach to non-compliant members and works closely with the Local Health Departments (LHD) in an attempt to bring members into care. Providers should use the Outreach Referral Form and fax this completed form to 410-933-2232 or 888-891-2232. . 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 Chapter 2 have specific guidelines surrounding referrals to the Local Health Departments. Providers should be aware of referral guidelines surrounding these populations and ensure that members who miss appointments are referred to the outreach department and the LHD timely and appropriately.

Transportation Guidelines

MedStar Family Choice will assist in the coordination of transportation for members that meet the appropriate medical criteria. Please contact 800-905-1722 if a member requests transportation. Requests for transportation can be made Monday-Friday from 8:30am to 5pm. The address, date, time and telephone number of the appointment should be available. Transportation for routine care must be requested 5-7 days in advance. Urgent requests are an exception; however, MSFC requests as much advance notice as possible. If the LHD will not provide transportation and the member meets the MSFC transportation criteria, MSFC will provide bus tokens or cab transportation. Our specific transportation criteria can be found on our website at www.medstarfamilychoice.com.

Bus Guidelines

Tokens will be provided for bus transportation for routine appointments which includes vision, and medical appointments. Bus transportation will not be approved for mental health appointments, methadone appointments, to pick-up prescriptions, or PT/OT/ST appointments.

Cab Guidelines

Cab transportation will be provided to members with urgent same day appointments. Members with medically related routine issues or chronic medical conditions should be referred to the LHD for assistance with transportation. The provider should assist the member in completing the required LHD medical forms for transportation authorization.

Transportation Guidelines for Pregnant Women

Cab transportation may be provided if the member is considered to have a "high risk" pregnancy. This must be documented by the OB doctor and provided to MSFC before cab transportation will be approved. Cab transportation may be provided in inclement weather such as extreme heat or freezing rain. Cab transportation may be provided if the member is more than 7 ½ months pregnant.

Other Instances When Cab Transportation May Be Approved

Cab transportation may be approved if the member is not on the bus line, and this is verified through MTA. Members may also be approved for cab transportation if the member lives 2 or more miles from the bus stop. A newborn baby's first well-child visit may also qualify the member for cab transportation.

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. These services are provided telephonically.

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 as defined by COMAR, who are not otherwise covered by a MedStar Family Choice 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
- Diabetes (Adult and Pediatric)
- High-risk Pregnancy
- HIV/AIDS
- Pain Management needs
- Substance abuse
- Wound needs
- Adult Respiratory

Members of MedStar Family Choice do not have to enroll; they are automatically enrolled when we identify them with one 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 410-933-2205 or 855-855-2205 or call MSFC Case Management Department at 410-933-2200 / 1-800-905-1722. Any faxes or voice messages received 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.

HEALTH EDUCATION CLASSES

MedStar Family Choice Members are able to sign up for a variety of health education classes that are sponsored by the MedStar Health hospitals. 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 latest listing of classes can also be found on the website. 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.

INTERPRETER SERVICES

MedStar Family Choice does provide interpreters for members that require such services. MedStar Family Choice utilizes a language line and can provide for in-office translation services when necessary. Providers may contact the Care Management Department at 1-800-905-1722 to

schedule telephonic translation services. Providers may contact Provider Relations (800-905-1722 opt6) to schedule in office translation services.

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 EVS prior to rendering services to MSFC members. The phone number for EVS is 1-866-710-1447. The DHMH also allows providers to verify eligibility on-line. The website is www.emdhealthchoice.org. When providers call the EVS line, they will automatically be connected to the Member's MCO to verify PCP information. MSFC members may change PCPs at any time. Members can call MSFC Member Services Monday-Friday 8:30am-5pm 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 is 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 8:30a.m. to 5:00 p.m. (1-800-905-1722) to answer any eligibility or PCP questions.

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 Maryland 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 Maryland Uniform Consultation Form should also be mailed or faxed to MSFC Care Management at the following address:

MedStar Family Choice
Care Management Department
8094 Sandpiper Circle, Suite O
Baltimore, MD 21236
Phone: 1-800-905-1722
Fax: 410-933-2274 or 888-243-1740

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 Maryland Uniform Consultation Referral Form. The Specialist must clearly indicate the PCP's approval on the referral. ***Exception: Specialists should directly refer patients for routine radiology, laboratory testing, rehabilitation, and DME services.***

Laboratory Referrals

Laboratory Corporation of America (LabCorp) is the contracted laboratory vendor for MedStar Family Choice patients. Members should be referred to LabCorp 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) 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 free-standing radiology facilities in the Baltimore Metropolitan area. 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 (800-905-1722 opt 6)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.

Rehabilitation Referrals

MSFC has an exclusive 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). PT/OT/ST and audiology services for members under the age of 21 are not covered by MedStar Family Choice. The State of Maryland reimburses for these services. Please make sure that when you refer a member under the age of 21 for any of these services that the provider participates in Maryland Medicaid. Chiropractic services are not covered for adults.

Self-Referrals for Vision, and Substance Abuse

Members may ask for information regarding routine vision or substance abuse services. The members may self-refer to the vendors indicated below for these services. Please note that for substance abuse services, the self-referral guidelines under the HealthChoice Program stipulate that members may also self-refer outside of the MCO network to an ADAA certified provider. No referrals are required.

Vision	1-866-998-5005	Advantica Eye Care
Substance Abuse	1-800-496-5849	Value Options

Urgent/Emergent Referrals

For patients requiring immediate services, please call MSFC Care Management at 1-800-905-1722 or fax the Maryland Uniform Consultation Referral Form to 410-933-2274.

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 8:30am-5pm at 410-933-2200 or 1-800-905-1722. The fax number is 410-933-2274 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 name and telephone number to contact for after hours needs. The message also contains beeper number for MSFC representative to be contacted for urgent pharmacy issues.

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 Maryland 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
- Medicare and Medicaid Guidelines
- COMAR
- MSFC MCO benefit coverage
- MSFC Provider Manual
- MSFC Member Handbook
- FDA Approval
- Maryland Medicaid DMS/DME Program Approved List of Items
- Availability of services within the MSFC network
- MSFC Continuity of Care Policy
- Pain Management Contracts

MSFC reserves the right to direct services to participating providers and facilities. Services outside the network are available only when they are not available within the network, for continuity reasons.

MedStar Family Choice's utilization management decision making is based on the medical necessity of the service and the existence of MCO enrollment and coverage.

MedStar Family Choice requires up to two business days to process a complete, non-urgent authorization request. Requests are considered complete when all necessary clinical information is received from the requesting provider. The final decision cannot take longer than seven days, whether or not all clinical information has been received. If the service requested is denied the provider may contact our Care Management Department to discuss the decision with the appropriate physician advisor.

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, a COMAR defined self referral service or a continuity of care.

Services that are carved out to the State of Maryland Medicaid, which include, but are not limited to, pediatric outpatient rehabilitation services and mental health care are subject to administrative denial since they are not the liability of MedStar Family Choice.

Pharmacy

MSFC pays for a wide variety of medications, as outlined in our MedStar Family Choice Formulary.

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 at 410-933-2200, or fax requests to 888-243-1790.

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.

Medications covered by the Department of Health and Mental Hygiene, such as HIV/AIDS medications and mental health drugs are not covered by MSFC. These requests are subject to administrative denials since they are not the liability of MSFC.

Concurrent Review

MSFC utilizes the following criteria to make concurrent review decisions:

- InterQual
- Medicare and Medicaid Guidelines
- COMAR
- MSFC MCO benefit coverage
- Availability of services within the MSFC network

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.

Services that are carved out to the State of Maryland Medicaid, which include but are not limited to mental health care, are subject to administrative denial since they are not the liability of MSFC.

MSFC follows MD Medicaid Fee for Service guidelines when conducting inpatient review in the event that a guardianship hearing is necessary to determine post acute disposition. In the absence of medical necessity, MSFC approves the first 2 days following the decision that guardianship is needed.

Emergency Care

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.

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 HSCRC guidelines for reasonable clinical care time.

Services that are carved out to the State of Maryland Medicaid, which include but are not limited to mental health care, are subject to administrative denial since they are not the liability of the MCO.

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 1-800-905-1722 or 410-933-2200

MedStar Family Choice requires up to two business days to process a complete authorization request. Requests are considered complete when all necessary clinical information is received from the provider. The final decision cannot take longer than seven days, whether or not all clinical information has been received. If service request is denied, the provider may contact the Care Management Department by calling 1-800-905-1722 and request to speak with the appropriate physician advisor regarding the denial.

For members with urgent authorization needs, physicians or a physician's staff member should contact MedStar Family Choice Care Management at 410-933-2200 or 1-800-905-1722. A decision regarding urgent authorizations will be made within 24 hours of receiving the request.

Services Requiring Prior-Authorization

- Ambulance/Wheelchair Van Transportation
- Ambulatory Surgery
- Cardiac Rehabilitation
- Chiropractic services (>10 visits) (not covered for >21 yrs)
- Clinic specialty visits in regulated space of non-participating hospital
- Cosmetic Procedures
- Diabetes Education & Nutritional Consults
- Durable Medical Equipment (>$1,000.00 or rental equipment >90 days)
- Elective Procedures or Admissions
- Facility based diagnostic services with exception of AFI, amniocentesis, BPP, EEG, fetal fibronectin, and fetal stress tests
- Home Health and Hospice
- Hyperbaric Oxygen

- Infusion/Injectibles (see below)
- Investigational surgeries
- Lithotripsy w/facility fee
- Neuropsychological testing
- Orthotics (ie braces/splints)(greater than $250 for the total claim)
- Out of network services of any kind
- Outpatient Rehab-PT/OT/ST (>10 visits) for >21 years
- PET scans
- Prosthetics (including foot orthotics and custom shoes)
- Pulmonary Function Tests (facility based)
- Pulmonary Rehabilitation
- Skilled Nursing Facility
- Soft Supplies (>$350.00 per member per month)
- Sonograms (for more than 3 if OB related and any if hospital based or non-OB related)
- Subacute/Inpatient Rehabilitative Services
- Sleep Studies
- Urgent/Emergent Procedures or Admissions (prior authorization is not required, but notification within 24-48 hours is mandatory)
- Wound care in a regulated setting

Prior Authorization Notes:

- Genetic counseling must be performed by the OB/GYN.
- Dialysis does not require prior authorization and is a self-referred service. We encourage providers to suggest a contracted facility when possible.
- 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 Franklin Square Hospital or Harbor Hospital without an authorization.

<u>Injectibles and Non-Formulary Medications Requiring Prior-Authorization</u>

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 800-905-1722 opt 6.

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 MD law. MedStar Family Choice accepts electronic submissions for both professional claims and institutional claims.

HIPAA compliant 837 files for **professional claims** through:

- Capario (formerly Medavant and Proxymed)
- Emdeon
- RelayHealth (aka McKesson)

Institutional claims are accepted through:

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

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 clearing house, 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
10201 N. Port Washington Rd
Mequon, WI 53092
Phone: 1-800-261-3371 (Monday-Friday 8:30am-5pm)

Clean claims will be paid within 30 days, in accordance with Maryland 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
8094 Sandpiper Circle
Suite O
Baltimore, MD 21236
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

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 Maryland 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.

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
10201 N. Port Washington RdMequon, WI 53092

Section IV

HealthChoice Benefits and Services