Hepatitis C Therapy - Important Guideline Updates

On December 1, 2018, the Maryland Department of Health is implementing changes to the hepatitis C treatment guidelines for Maryland Medicaid recipients. MedStar Family Choice follows these guidelines. Below is a summary of the changes:

- Fibrosis requirements have been lifted for patients with “a viral condition which is known (documented) to result in an accelerated hepatic disease (fibrosis) progression and/or hepatic decompensation than what is normally expected from the course of chronic HCV.” For example, members with HIV or hepatitis B do not have fibrosis requirements; they can be Metavir F0, F1, F1-2, etc. and qualify for treatment.
- If HIV positive, a viral load that is less than 6 months old must be submitted with the Prior Authorization request.
- If hepatitis B positive, a viral load that is less than 6 months old must be submitted with the Prior Authorization request.
- The following medications will no longer be approved:
  - Viekira (paritaprevir/ritonavir/ombitasvir plus dasabuvir)
  - Technivie (ombitasvir/paritaprevir/ritonavir)
  - Olysio (simeprevir)

Please contact MedStar Family Choice at 800-905-1722, option 2 for Prior Authorization of hepatitis C therapy. Should you have any questions or concerns, please call Dr. Danielle Gerry at 410-933-2295.

1099 Statements

MedStar Family Choice will be mailing 1099 statements during the month of January. The 1099s are mailed to the last W-9 address we have on file. It is possible that you may not receive your statement in the mail if MedStar Family Choice was not notified that the W-9 address we have on file for your office changed in the previous year.

Providers who need to update their billing address information should email their updated billing information along with a W-9 to MedStar Family Choice Provider Relations at mfc-providerdemographics@medstar.net or fax to 410-933-3077. Your information will then be updated in our system. If your W-9 address did not change and you received your 1099 statement for the last calendar year through the mail, then you do not need to send an update. All requests for a copy of a 1099 statement should be directed to 800-261-3371. Please contact Provider Relations with questions and concerns at 800-905-1722, option 5.
Update to the MedStar Family Choice Formulary

Details of the prior authorization criteria are available on the MedStar Family Choice Pharmacy webpage with the other pharmacy protocols. For more information, please call the MedStar Family Choice Provider Relations department at 800-905-1722, option 5.

CHANGES BELOW ARE EFFECTIVE AS OF JANUARY 1, 2019.

Additions:
- Copaxone (glatiramer sol) BRAND injection 10mg/mL
- Soliqua (insulin glargine-lixisenatide)
- Steglatro (ertugliflozin)
- Segluromet (ertugliflozin-metformin)
- Humira (adalimumab) Pen Kit for Crohn’s disease, UC, and hidradenitis
- Humira (adalimumab) Pen Kit for psoriasis and uveitis
- Cosentyx (secukinumab)
- Stiolto Respimat (tiotropium-olodaterol)
- Proair RespiClick (albuterol)

Prior Authorization* now required for:
- Jardiance (empagliflozin)
- Synjardy/Synjardy XR (empagliflozin/metformin)

Additions with Prior Authorization* required:
- Jivi (antihemophilic factor recombinant pegylated-aucl)

Step Therapy formulary changes:
- Ranexa (ranolazine) no longer requires step therapy

Managed Drug Limitations & Step Therapy**:
- Ranexa (ranolazine) no longer requires step therapy

Removals*:
- Invokana (canagliflozin)- all doses and formulations
- Invokamet (canagliflozin-metformin)- all doses and formulations
- Levonortestrel 0.75mg emergency contraception was removed from the market and is no longer available.
- Norethindrone and Mestranol 1 mg- 50 mcg emergency contraception was removed from the market and is no longer available.
- Taltz (ixekizumab)
- Soma (carisoprodol)

*Details of the prior authorization criteria are on the MedStar Family Choice website in the Prior Authorization Table.

**Details of the step therapy criteria are on the MedStar Family Choice website in the Step Therapy Table.
Clinical Practice and Preventive Guidelines

Participating providers should review the clinical practice guidelines, as well as the preventive guidelines, posted on the MedStar Family Choice website, MedStarFamilyChoice.com, for updates. These guidelines are updated every two years. Currently, the clinical practice guidelines include the following:

- Management of Pediatric ADHD
- Diagnosis and Management of Asthma in Adults
- Diagnosis and Management of Asthma in Children and Adolescents
- Diagnosis and Management of Pediatric Acute Asthma Exacerbation
- Treating Acute Asthma Exacerbations in Adults and Children
- Management of Acute Low Back Pain in Adults
- Management of Bronchiolitis in Pediatrics
- Management of Bronchitis—Adults
- Bronchitis—Children and Adolescents
- Diagnosis, Management and Prevention of COPD
- Outpatient Diagnosis and Management of Venous Thromboembolic Disease
- Identification and Management of Clinical Depression in Adults
- Management of Adult Diabetes Mellitus
- Assessment and Prevention of Falls in the Elderly
- Management of Hyperbilirubinemia in the Healthy Newborn
- Management of Hypercholesterolemia
- Management of Hypertension in Adults
- 2018 Immunization Schedules – Adult and Pediatric
- Prescribing Naloxone in the Outpatient Setting
- Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity
- Identification, Evaluation, and Treatment of Overweight and Obesity in Adults
- Management of Osteoporosis
- Managing Otitis Media in Children
- Opioids for Pain Management
- Cervical Cancer Screening for the Primary Care Physician
- Guideline for Perinatal Care
- The Diagnosis and Management of Pharyngitis in Adults
- The Diagnosis and Management of Acute Group A Streptococcal Pharyngitis in Adolescent and Pediatric Patients
- Community Acquired Pneumonia – Adult
- Community Acquired Pneumonia – Pediatric
- 2018 Preventive Screening Recommended Guidelines – Adult and Pediatric
- Outpatient Use of Proton Pump Inhibitors
- Management of Sinusitis – Adult
- Management of Sinusitis in Children Ages 1 to 18
- Outpatient Management of Pediatric Urinary Tract Infection

All clinical practice guidelines are PDFs and can be downloaded. Alternatively, you may contact Provider Relations at 800-905-1722, option 5, to request hard copies of these guidelines.
Case Management Services and Additional Benefits

MedStar Family Choice has a highly qualified team of nurses and social workers to assist in caring for our members. We offer different types of telephonic case management services, depending on your patient’s needs. Our nurses and social workers may contact you to collaborate, share clinical information, or to verify that services were rendered. We will forward the care plan for your patients enrolled in case management services and welcome your feedback.

Types of case management services

Catastrophic

Catastrophic Case Management is a service MedStar Family Choice provides when your patients have complex care needs. This service is provided by case managers who are registered nurses. They work closely with you and your patients. They will talk with your patient by phone to help arrange doctor visits, medical equipment, therapy, education, and other services your patients may need.

Complex and Condition Care

Complex Case Management and Condition Care Case Management are other case management services that MedStar Family Choice provides when your patients have certain medical conditions. This service is provided by case managers who are registered nurses or social workers. The case managers provide education on chronic medical conditions, and can help your patients to take charge of their health.

Case managers will help your patient to find providers to treat and manage their condition, medical equipment, therapy, and other services that your patient(s) may need.

Transition Care

Transition Care Case Management is a service provided by MedStar Family Choice to assist your patient if they were just discharged from the hospital. This service is provided by case managers who are registered nurses. They will work closely with your patient to assist your patient with following the discharge plan ordered by the hospital doctor. They will assist your patient with locating needed providers and will assist with scheduling the follow-up appointments that may be needed. This service lasts for 30 days. If your patient needs more help after that period of time, your patient will be referred to one of our other case management programs where your patient can continue to get assistance.

Rare and Expensive Case Management (REM)

For your patients with a diagnosis that makes them eligible for REM, we reach out to the member and provide education about the Maryland Medicaid REM program. If the member is agreeable, the REM application is completed and submitted to the MDH REM unit. If you have a patient that has a REM qualifying diagnosis please contact the case management department by calling us at 800-905-1722, option 2.

Enrollment

Your patients do not have to enroll in case management services. If your patients have certain conditions or medical needs, a case manager may reach out to your patient for enrollment in case management services. Enrollment in case management is voluntary. We hope that you and your patients find our case management services to be very helpful. You or your patients may also request case management services by calling us at 800-905-1722, option 2.
Available Benefits for MedStar Family Choice Members

Free Smartphone!
A free smartphone with 1 GB of data and 350 monthly minutes, unlimited text messages, and free calls to MedStar Family Choice. Call 877-631-2550 for more information.

Resource Connection
A case manager can connect your patients with resources in their community to assist them with mental and/or substance abuse needs, utility turn offs, food assistance, and emergency shelters.

Educational Materials
Flyers and handouts with information on chronic conditions are available to MedStar Family Choice members. The information is written in easy-to-understand language. A case manager is available to answer your patient’s questions and concerns. Your patient’s case manager can also advise your patient on wellness incentives that may be available to them.

Coordinate Care
A case manager can assist your patient with locating a primary care provider and/or specialty provider in their area. A case manager can also assist your patient with scheduling their appointments. If your patient needs help getting to their medical appointments, a case manager can help your patient with options for transportation.

800-905-1722, select option 2 PHONE

Health Education Schedule
We offer health education classes free of charge to MedStar Family Choice members. Classes are designed to appeal to our members on many health levels. For example, prenatal classes are available for moms-to-be, along with education for infant safety and sibling classes. These are just a few classes offered through the birth and family education listings. In addition to these classes, MedStar Health hospitals offer blood pressure screenings, and cancer, diabetes and heart disease education, as well as smoking cessation support. Providers are encouraged to refer members to these classes and document the referrals, as well as the member’s feedback, in the member’s chart.

Visit MedStarFamilyChoice.com for a complete listing of classes. If you do not have access to the Internet, you may call MedStar Family Choice Provider Relations at 800-905-1722, option 5, for a listing of classes.

Updated Emergency Room Auto-Pay List for 2019
The updated Emergency Room Auto-Pay List effective for dates of service starting on January 1, 2019 is now available on the MedStar Family Choice website.

Please note that claims for emergency services with a primary ICD-10-CM diagnosis code on the auto-pay list will be paid without further documentation for the appropriate dates of service.

MedStar Family Choice 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).

If you have any questions about the auto-pay list, please contact our Provider Relations department at 800-905-1722, option 5, Monday-Friday between 8:30 a.m. - 5:00 p.m.
Emergent Care Project

MedStar Family Choice has initiated an Emergent Care Project with the goal to decrease avoidable Emergency Department (ED) usage by its members. The focus of the project will be on MedStar Family Choice members with high-dollar utilization of the ED. The Emergent Care Team will meet to discuss members in the program and will include MedStar Family Choice associates from Case Management, Outreach, Social Work, Emergent Care, Community Relations, and Quality. MedStar Family Choice is striving to improve care for members through face-to-face visits. From the face-to-face visit, MedStar Family Choice will determine barriers to care and then work to overcome those barriers. Barriers to primary care can include accessibility, transportation, safety concerns, and others.

Members are being contacted by the MedStar Family Choice Emergent Care RN, who has over two decades of ED experience. She will be meeting with the MedStar Family Choice members to discuss their recent ED visits and barriers to seeing their primary care provider. The members will be provided with information regarding use of the 24-hour Nurse Advice Line, a list of available urgent care providers and the opportunity to apply for a Safelink cell phone. Each member in the program will have one home visit per week for up to four weeks as needed.

Initially MedStar Family Choice will reach out to the member by phone and during that phone call schedule a face-to-face meeting. During the initial face-to-face home visit the Emergent Care RN will determine the member’s barriers to care as well as medical needs. On the second home visit, if Case Management is needed, the Emergent Care RN will be accompanied by an MedStar Family Choice Case Management RN. This meeting will allow the member to meet face-to-face and engage with their Case Manager as well as focus on the specific health care needs of the member. The Emergent Care nurse and/or the Case Management Nurse will assist with transportation, social work issues, and medication/prescription access as well as primary care access issues.

The Emergent Care RN may also contact the member’s Primary Care Provider via MedConnect. Information related to upcoming primary care visits, labs needed (such as hemoglobin A1C, renal function, electrolytes, etc.), chronic care needs (diabetic eye exams, pulmonary follow up, medication refills, immunizations, etc.), and barriers to care will be communicated. This face-to-face engagement will help MedStar Family Choice to establish a strong relationship with these members, with the ultimate goal of offering and coordinating improved access to appropriate care overall. The Emergent Care RN will then transfer the member to Case Management if indicated. Member satisfaction will be measured through a post-program follow-up phone call.

Providers Responsible to Report Overpayments or Improper Payments Within 60 Days

MedStar Family Choice encourages providers to conduct regular self-audits to ensure accurate payment. Medicaid funds that were improperly paid or overpaid must be returned within 60 days of discovery. If your practice determines it has received overpayments or improper payments, you are required to:

- Return the overpayment to MedStar Family Choice within 60 calendar days after the date on which the overpayment was identified.
- Notify MedStar Family Choice in writing of the reason for the overpayment.

If you receive an overpayment for your claims, contact MedStar Family Choice Claims department at 800-261-3371 and then send the refund, the reason for the overpayment and a copy of the Explanation of Payment(s) identifying the overpayment to the address below:

MedStar Family Choice
Maryland Claims
P.O. Box 2189
Milwaukee, WI 53201
800-261-3371
Member Complaint/Grievance and Appeal Process

The MedStar Family Choice complaint/grievance and appeal procedure that members follow can be found on our website at MedStarFamilyChoice.com and in your provider manual.

If you do not have access to our website or a provider manual, you may contact Provider Relations at mfc-providerrelations2@medstar.net or 800-905-1722, option 5, for a copy of the manual. The process will tell you the following:

• How members can file a complaint, grievance or appeal, and the differences between them
• How quickly we will respond to the member and the provider
• What to do if the member does not agree with our decision

Please note that providers may not appeal a decision on the member’s behalf without written permission from the member.

Members have the right to contact the HealthChoice Enrollee Help Line at 800-284-4510, Monday through Friday, 7:30 a.m. to 5:30 p.m., when they have a concern about a decision made by MedStar Family Choice.

MedStar Family Choice Site Evaluations

Site surveys are completed for all MedStar Family Choice PCPs and specialists at the time of initial credentialing. If a member complaint is received about the physical condition of the provider office, a follow-up site audit will be performed.

New provider sites and site additions also require a site evaluation after MedStar Family Choice Provider Relations is notified of the change or addition.

Claims for visits at the new location will be treated as out of network until the site visit has taken place.

If you have any questions or comments regarding minimum standards for site evaluations, please contact your provider representative at 800-905-1722, option 5.

Redetermination Process

Medicaid recipients must renew their eligibility every 12 months. This process is also known as getting a “redetermination.” Redeterminations for most Medicaid recipients will now be processed in Maryland Health Connection. Maryland Health Connection will process redeterminations for the following recipients:

• Under 65 years of age
• Parent or caretaker relative of a minor child
• Pregnant women
• Children enrolled in Medicaid
• Former foster care children

Some redeterminations will continue to be process through the local Department of Social Services (DSS). The local DSS will continue to process redeterminations for the following recipients:

• Over 65 and are not a parent or caretaker relative of a minor child
• Blind
• Disabled
• Living in a nursing facility
• Current foster care children

Recipients are mailed letters from Maryland Medicaid 45 to 60 days in advance of their redetermination deadline. We encourage you to discuss redetermination requirements with your patients to make sure they are completing their redetermination applications in a timely manner.

For recipients who are enrolled in a managed care organization: If a recipient loses coverage due to not completing his or her redetermination application, the recipient will be re-enrolled into the same managed care organization he or she was in previously if the gap in enrollment is less than 120 days.
Provider Appeal Process

MedStar Family Choice providers must follow steps when submitting both administrative and clinical appeals as a result of a denial or reduction in reimbursement for services rendered. In order to help providers address simple administrative appeal requests and formal clinical appeal requests, we have created templates to help with this process. Using the templates is optional and the forms include a Medicaid Administrative Claim Reconsideration form, a Medicaid Provider Claim Assistance/Project Request, a Medicaid Claim Appeal and/or a Formal Clinical Appeal form. For administrative appeal requests, providers can submit one or more of the following forms:

- **Medicaid Administrative Claim Reconsideration Form:**
  This form can be used when asking MedStar Family Choice to reconsider a previously submitted claim that was denied for timely filing (proof of timely filing required), a claim that was denied as a duplicate in error, a corrected claim (including modifiers), submission of information previously requested by MedStar Family Choice, coordination of benefits (COB), service not paid at contracted rates, processed participating provider as out-of-network in error, claim processed with a TIN that was different from the TIN billed, denied for lack of authorization in situations where an authorization was obtained, requests for refunds/stop payments or other administrative type claim denials.

- **Medicaid Provider Claim Assistance/Project Request:**
  This form can be used when providers request the assistance of Provider Relations with larger claim issues that involve multiple claims issues for one member or single claim issues for multiple members.

- **Medicaid Formal Claim Appeal:**
  For a formal claim appeal request, providers can submit a Medicaid Formal Claim Appeal form Initial Claim Appeal should be requested within 90 business days of the explanation of benefits (EOB) denial. The appeal must outline reasons for the claim appeal with all necessary documentation including a copy of the claim and the EOB. Providers will receive a decision via an EOB within 30 calendar days of receipt of the request. If a provider is not satisfied with the decision of the first-level appeal because the decision was upheld, a second-level appeal can be submitted. Second-level appeals must be received within 30 calendar days of the date of the first-level appeal notification letter. 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. Claim Appeals should be sent in writing to:

  MedStar Family Choice
  P.O. Box 43730
  Baltimore, MD 21236
  Attn: Claims Appeals Department

  Claim denials that are overturned on appeal will be paid within 30 calendar days of the decision. Templates for claims appeals can be found in our provider manual and on our website at MedStarFamilyChoice.com. Providers can also request hard copies of all forms by contacting Provider Relations by calling 800-905-1722, option 5.

  ***This is not to be used for a formal clinical appeal request. See below.

- **Medicaid Formal Clinical Appeal:**
  For formal clinical appeal requests, providers can submit a Formal Medical Necessity Appeal. This form should be used when the provider is acting on their own behalf and is disputing an adverse determination when the service has already been provided to the member. Clinical first-level appeals should be requested within 90 business days of the date of the denial letter and include a written request outlining reasons for the appeal. Submit all necessary documentation including pertinent medical records. Providers will receive a response to their appeal within 30 calendar days of receipt of the request. If a provider is not satisfied with the decision of the first-level appeal because the decision was upheld, a second-level appeal can be submitted. Second-level appeals must be received within 30 calendar days of the date of the first-level appeal notification letter. 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. Appeals should be sent in writing to:

  MedStar Family Choice
  P.O. Box 43790
  Baltimore, MD 21236
  Attn: Clinical Appeals Department

  Clinical denials that are overturned on appeal will be paid within 30 calendar days of the decision. Templates for clinical appeals can be found in our provider manual and on our website at MedStarFamilyChoice.com. Providers can also request hard copies of all forms by contacting Provider Relations at 800-905-1722, option 5.

**Member Appeals:** The service has not yet been provided. Providers can act on behalf of a member to request an Appeal of an Adverse Action that results in member financial liability or denied service. The provider must have the member’s written consent to act on behalf of the member. The appeal must be received within 65 days from the date on the “Denial of Services” letter. Member Appeals has one level only.
Pharmacy and Therapeutics Committee

MedStar Family Choice has an active Pharmacy and Therapeutics Committee that meets the third Wednesday of every other month from noon to 1:30 p.m. Please consider getting involved and bringing your expertise and input to this committee. Some of the activities of the committee include:

- Reviewing and updating policies and procedures for pharmaceutical management
- Assessing drug utilization patterns and making recommendations for projects to address issues as they arise
- Reviewing the MedStar Family Choice closed formulary, at least annually, and evaluating requests for additions/deletions to the formulary
- Developing interventions to ensure the safe use of medications.

If you are interested in joining the Pharmacy and Therapeutics committee, please contact your Provider Relations representative at 800-905-1722, option 5.

Asthma Compliance Initiative

Asthma is a chronic lung condition that affects the entire population in a multitude of ways, having a significant impact on the quality of life and cost of healthcare. Per the CDC, one in 12 adults and one in 11 children had asthma in 2010. It is a condition that costs the United States $56 billion each year. The hospitalization costs related to asthma topped $73 million, while asthma related Emergency department visits totaled $26 million in 2009. The state of Maryland is one of 36 states that receive funding and technical support from the Centers for Disease Control and Prevention’s National Asthma Control Program. For more information, please visit CDC.gov/Asthma.

MedStar Family Choice is participating in a Maryland Department of Health Performance Improvement Project designed to target our member population who are non-compliant with asthma controller medications. There is a direct correlation with increased use of controller medications and decreased use of rescue inhalers to improved management of asthma, and vice versa. In order to take an active role in monitoring use of asthma controller medications, a system-wide ban on providing samples of asthma medications within MedStar provider offices was instituted.

In addition to eliminating samples, MedStar Family Choice has taken one step further to evaluate and amend the mail-order formulary to include 100 percent coverage for all asthma controller medications written for a 90-day supply. This would eliminate the barrier many members face regarding lack of transportation to their local pharmacy.

The Quality Improvement (QI) Specialists are contacting members by phone that have been identified as non-compliant through claims data. By engaging the member, the goal is to evaluate, identify, and remove any barriers they may be facing, resulting in non-compliance. Additionally, they are reaching out to offices to arrange appointments and provide offices with the mail order enrollment forms. For members who are not interested in mail order MFC has recently implemented a Retail 90 benefit. Please consider these prescribing options for our members with Asthma.

With the provider offices’ involvement, the future is bright with improving member compliance with asthma controller medications, thus reducing the overall costs that incur as a result of uncontrolled asthma.
Did you know?

When addressing tobacco dependence …

• Combining long-acting nicotine replacement treatment (NRT) options—like the patch—with short-acting NRT—such as the gum, lozenge or spray—can support quitting.

• Combination pharmacotherapy—using Varenicline and Bupropion SR together—appears to be more effective than use of either alone (Ebbert et al., 2009).

Visit MDQuit.org/Cessation-Programs.

Connect to Quit Corner

Ask, Advise, Assess. Connect to Quit.

MDQuit.org

Maryland’s

1-800 QUIT NOW

SmokingStopsHere.com
Credentialing and Recredentialing

Credentialing
MedStar Family Choice uses the Council for Affordable Quality Healthcare (CAQH) ProView database to streamline credentialing, reduce the amount of time and resources needed for credentialing, and to help improve provider data accuracy.

New physicians and other healthcare professionals joining and existing group that's currently participating/contracted with MedStar Family Choice should complete and submit the MedStar Family Choice CAQH Medical Data Sheet along with a copy of their Disclosure of Ownership and Control Interest Statement.

Physicians and other healthcare professionals who do not use CAQH ProView may complete and submit the appropriate state credentialing application:

- Maryland- Maryland Uniform Credentialing Form (MUCF)

If you or your group are currently not participating/contracted with MedStar Family Choice, please contact Provider Relations department at 800-905-1722, option 5 for contracting and credentialing questions.

Credentialing Requirements:

- A complete CAQH or MUCF state credentialing application
- Active privileges in good standing at a MedStar Family Choice participating hospital
- A current, valid and unrestricted state license to practice
- A current, valid, unrestricted DEA or CDS certificate, if applicable
- Board Certified, or must be Board Eligible/Qualified in practicing specialty (specialists only)
- Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986
- Current Malpractice Coverage (minimum amounts of $1M each occurrence /$3M per aggregate)
- Work history for most recent five years (employment gap that exceeds 6 months must be explained)

Recredentialing
MedStar Family Choice recredentials its physicians and other healthcare professionals at least every 36 months (3 years) in order to comply with state and federal regulation, and in accordance with the National Committee for Quality Assurance (NCQA) credentialing standards. The CAQH system provides a time saving solution that lets MedStar Family Choice obtain up to date information for recredentialing. Physicians and other healthcare professionals only need to spend a few minutes each quarter to confirm (re-attest) that their credentialing information is complete and accurate.

To complete the recredentialing process, MedStar Family Choice will obtain physician and other healthcare professional applications and supporting documents directly from the CAQH system. To avoid delays during this process, physicians and other healthcare professionals should:

- Maintain a current CAQH ProView profile.
- Review their data and re-attest to its accuracy every 120 days.
- Upload current supporting documents directly into CAQH ProView (e.g., current malpractice insurance certificate, board certification certificate, etc.) to eliminate the need for manual submission, and to improve the timeliness of completed applications.

Physicians and other healthcare professionals who do not have a CAQH ProView profile will receive a recredentialing request letter approximately six months prior to their recredentialing date, and the letter will include instructions for submitting the recredentialing application and supporting documents. Physicians and other healthcare professionals may be terminated from the MedStar Family Choice network for failure to submit and/or provide updated documents needed to complete the recredentialing process in a timely manner.
MedStar Family Choice Survey Results

MedStar Family Choice wants you to stay informed on how we are doing. For updated information on survey results such as HEDIS, Satisfaction Surveys, System Performance Reviews, EPSDT audits, and the Consumer Report Card, please visit the MedStar Family Choice Quality Assurance and Monitoring webpage:  

Paper copies are available upon request by calling 888-404-3549. As we continue to improve and strive for high scores, your dedication to quality health care is very much appreciated.

HEDIS is a registered trademark of the Nation Committee for Quality Assurance (NCQA).
CAPHS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Paper Claims Address Reminder

All claims and overpayment refunds should only be mailed to the new address at:

MedStar Family Choice Maryland Claims
P.O. Box 2189
Milwaukee, WI 53201
800-261-3371

MedStar Family Choice accepts electronic claims submissions for both professional claims and institutional claims. Claims can be submitted using the following online services:

Professional Claims
• Capario (formerly Medavant ProxyMed) - Payer ID 00243
• Change Healthcare (formerly Emdeon) - Payer ID 39190
• Change Healthcare (formerly Relay Health) - Payer ID 4775

Facility Claims
• Payerpath (aka Allscripts) - Payer ID 521995799
• Change Healthcare (formerly Emdeon) - Payer ID 39190
• Change Healthcare (formerly Relay Health) - Payer ID 3614
• XactiMed (Aka MedAssets) - Payer ID 521995799

Claims are also accepted directly via 837 and online claims submissions.