MedStar Family Choice

DISTRICT OF COLUMBIA

DC Healthy Families and DC Healthcare Alliance Provider Manual

2020

It's how we treat people.

DHCF Department of Health Care Finance

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.

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GENERAL INFORMATION

A. WELCOME TO MEDSTAR FAMILY CHOICE-DC

MedStar Family Choice-District of Columbia (MFC-DC) is a Managed Care Organization contracted by the District of Columbia Health Care Finance to provide services to enrollees in the DC Healthy Families and DC Healthcare Alliance programs. MFC-DC is a subsidiary of MedStar Health, a large not-for-profit, regional healthcare system that has a network of ten hospitals, ambulatory and urgent care locations, home care services, physician offices and other health care 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 30,000 associates and 5,400 affiliated physicians.

We are dedicated to building the type of Distributed Care Delivery Network necessary to provide effective, high quality health care to all DC Medicaid eligible populations enrolled in the District of Columbia Healthy Families program (DCHF) and DC Healthcare Alliance program (Alliance). MFC-DC believes that by offering physicians the appropriate managerial and systems support, MFC-DC will be able to help them do what they do best – practice medicine.

B. DC HEALTHY FAMILIES, IMMIGRANT CHILDREN PROGRAM AND DC HEALTHCARE ALLIANCE PROGRAMS

The District of Columbia Health Care Finance (DHCF) administers the District of Columbia Healthy Families (DCHF). Under the District of Columbia Healthy Families programs, Covered Services are provided to the following categories of eligible Medicaid Enrollees:

- Children 20 years of age and younger, including children eligible for Children's Health Insurance Program
- Parent, Caretaker, Relatives 21 years and over
- Childless adults 19 to 64 years of age
- Adults with Special Health Care needs 21 to 64 years of age who are ineligible for Medicare
- Enrollees placed in foster care, who, upon the discretion of Child and Family Services Administration (CFSA) elect to remain in the DHCFP

The DHCF also provides Covered Services through Immigrant Children Program (ICP), which includes immigrant children under the age of 21 who are not US citizens and are ineligible for Medicaid or CHIP. This population is eligible to receive the same Covered Services as children who are enrolled in DCHF.

The DC Healthcare Alliance Program (Alliance), also administered by DHCF, provides Covered Services to those who are 21 and older, are not US citizens but who are residents of the District of Columbia. The Covered Services available to Alliance do not include all Medicaid Covered Services and some limitations apply.

C. MEDSTAR FAMILY CHOICE-DISTRICT OF COLUMBIA WEBSITE

Enrollees and providers can access the MFC-DC website at **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 information and updates
- Fraud and Abuse information
- Hours of operation and after-hours instructions
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- Medical record documentation guidelines and policies
- Enrollee rights and responsibilities
- Notice of privacy practices
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- Pharmacy protocols and procedures
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- Provider Manual/Alerts
- 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 these materials are available in print by contacting our Provider Relations Department, Monday through Friday 8:00 a.m. to 5:30 p.m. at **855-798-4244**.

D. ENROLLEE RIGHTS AND RESPONSIBILITIES

Enrollees have the right to:

- Know that when they talk with their doctors and other providers it is private.
- Have an illness or treatment explained to them in a language they can understand.
- Participate in decisions about their care, including the right to refuse treatment.
- Receive a full, clear and understandable explanation of treatment options and risks of each option so they can make informed decisions.
- Refuse treatment or care.
- Be free from any form of restraints or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- See and receive a copy of their medical records and request an amendment or change, if incorrect.
- Receive access to health care services that are available and accessible to them in a timely manner
- Choose an eligible PCP/PDP from within MedStar Family Choice-DC's network and to change their PCP/PDP.
- Make a Grievance about the care provided to them and receive an answer.
- Request an Appeal or a Fair Hearing if they believe MedStar Family Choice-DC was wrong in denying, reducing or stopping a service or item.
- Receive Family Planning Services and supplies from the provider of their choice.
- Obtain medical care without unnecessary delay.
- Receive information on Advance Directives and choose not to have or continue any life-sustaining treatment.
- Receive a copy of MedStar Family Choice-DC's Enrollee Handbook and/or Provider Directory.
- Continue treatment they are currently receiving until they have a new treatment plan.
- Receive interpretation and translation services free of charge.
- Refuse oral interpretation services.
- Receive transportation services free of charge.
- Get an explanation of prior authorization procedures.
- Receive information about MedStar Family Choice-DC's financial condition and any special ways we pay our doctors.
- Obtain summaries of customer satisfaction surveys.
- Receive MedStar Family Choice-DC's "Dispense as Written" policy for prescription drugs.
- Receive a list of all covered drugs.
- Be treated with respect and due consideration for their dignity and right to privacy.

- Receive health care and services that are culturally competent and free from discrimination.
- Receive information, including information on treatment options and alternatives, regardless of cost or benefit coverage, in a manner the enrollee can understand.
- Exercise their rights, and that the exercise of those rights does not adversely affect the way MFC-DC, our providers, or the District of Columbia Healthcare Finance treats them.
- File appeals, grievances and Fair hearings with the District of Columbia.
- Request that ongoing benefits be continued during an appeal or state fair hearing however, the enrollee may have to pay for the continued benefits if the decision is upheld in the appeal or hearing.
- Receive a second opinion from another doctor within MFC-DC, or by an out-of-network provider if the provider is not available within MFC-DC, if the enrollee does not agree with the doctor's opinion about the services that the enrollee needs.
- Receive other information about how MFC-DC is managed including the structure and operation, as well as physician incentive plans.
- Receive information about the MFC-DC, its services, its practitioners and providers and enrollee rights and responsibilities.
- Make recommendations regarding the organization's enrollee rights and responsibilities policy.

Enrollees have the responsibility to:

- Inform their provider and MCO if they have any other health insurance coverage.
- Treat DHCF staff, MFC-DC staff, and health care providers and staff, with respect and dignity.
- Follow the rules of the DC Medicaid Managed Care Program and MedStar Family Choice-DC.
- Follow instructions received from their doctors and other providers.
- Be on time for appointments and notify providers as soon as possible if they need to cancel an appointment.
- Go to scheduled appointments .
- Tell their doctor at least 24 hours before the appointment if you must cancel.
- Ask for more explanation if they do not understand their doctor's instructions.
- Go to the Emergency Room only if they have a medical emergency.
- Tell their PCP/PDP about medical and personal problems that may affect their health.
- Report to Economic Security Administration (ESA) and MedStar Family Choice-DC if they or a member of their family (who is an enrollee) has other health insurance or if they changed their address or phone number.
- Report to Economic Security Administration (ESA) and MedStar Family Choice-DC if there is a change in their family (i.e. deaths, births, etc.).
- Try to understand their health problems and participate in developing treatment goals.
- Help their doctor in getting medical records from providers who have treated them in the past.
- Tell MedStar Family Choice-DC if they were injured as the result of an accident or at work.

- Show their enrollee ID card when they check in for every appointment.
- Report lost or stolen enrollee ID cards to MFC-DC.
- Call MFC-DC if they have a problem or a complaint.
- Work with their Primary Care Provider (PCP) to create and follow a plan of care that the enrollee and PCP agree on.
- Ask questions about their care and let their provider know if there is something they do not understand.
- Update the District if there has been a change in their eligibility status
- Provide the MFC-DC and our providers with accurate health information in order to provide proper care.
- Tell their PCP as soon as possible after they receive emergency care.
- Inform their caregivers about any changes to their Advance Directive.

E. HIPAA AND ENROLLEE PRIVACY RIGHTS

MFC-DC complies with all Federal and District laws and regulations around enrollee privacy and data security, including the Health Insurance Portability and Accountability Act (HIPAA), the Standards for Privacy of Individually Identifiable Health Information, the District of Columbia Mental Health Information Act, and the Confidentiality of Alcohol and Substance Use Disorder Patient Records. In addition, MFC-DC provides all new enrollees a copy of its Notice of Privacy Practices upon joining MFC-DC.
A copy of the notice is also available on our website. Provider Relations can provide copies of this notice upon request. The notice outlines how MFC-DC may use and disclose our enrollee's information and when authorization for use and disclosure is required. MFC-DC has appropriate policies and procedures in place to make sure that our enrollee's protected health information is safeguarded. These policies explain how MFC-DC protects verbal and written, electronic protected health information (including mobile devices).

F. ANTI-GAG PROVISIONS

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

(1) communications that relate to treatment alternatives including medication treatment options regardless of benefit coverage limitations;

(2) communication that is necessary or appropriate to maintain the provider-patient relationship while the enrollee is under the provider's care;

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

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

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

The provider must inform the enrollee of their right to appeal a coverage determination pursuant to MFC-DC's grievance procedures and according to law.

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

G. ASSIGNMENT AND REASSIGNMENT

DCHF Enrollees:

Enrollment packages will be sent to the head of the household for each group of enrollees in a family unit. Eligible enrollees 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 enrollees do not select an MCO during the thirty-day period from the date of notice, DHCF, through its enrollment broker, will use an algorithm to automatically assign an enrollee to an MCO.

Once 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.

Alliance and ICP Enrollees:

Alliance and ICP enrollees are auto-assigned to a health plan. Newly eligible enrollees shall have ninety (90) days from the date of managed care enrollment to transfer to another MCO.

Non-Discrimination Noice:

MFC-DC accepts all enrollees without regard to physical or mental condition, health status, need for health services, marital status, age, sex, sexual orientation, national origin, race, color, religion or political beliefs and shall not use any policy or practice that has the effect of such discrimination.

H. PRIMARY CARE PHYSICIAN SELECTION

All enrollees will have a Primary Care Physician. DC Healthy Families enrollees have the opportunity to select a PCP when enrolling in the program. If one is not chosen within 10 days of enrollment, a PCP will be assigned. MFC-DC will assist the enrollee in selecting a PCP. DC Healthcare Alliance and Immigrant Children Program enrollees are auto-assigned a PCP. MFC-DC will inform the enrollee of their right to choose their PCP and to change their PCP at any time.

When assigning a PCP, MFC-DC will consider several factors, including but not limited to:

- Enrollee's previous PCP if known
- Closest PCP to the enrollee's zip code
- Children in the same family assigned to the same PCP
- Children with known special health care needs assigned to providers with appropriate experience

MFC-DC enrollees may change PCPs at any time. Enrollees can call MFC-DC Enrollee Services Monday through Friday 8:00 a.m. to 5:30 p.m. at **888-404-3549** to change their PCP. PCPs may see MFC-DC enrollees even if the PCP name is not listed on the enrollee ID card. As long as the enrollee is eligible on the date of service and the PCP is participating with MFC-DC, the PCP may see the MFC-DC enrollee. However, MFC-DC does request that the PCP assist the enrollee in changing PCPs so the correct PCP is reflected on the enrollee ID card. The office should contact Enrollee Services **888-404-3549**. The PCP office may also submit a PCP change form to Enrollee Services, which is signed and dated by the enrollee wishing to change PCPs. This form is available on the MFC-DC website. MFC-DC's Outreach staff is available to providers Monday through Friday from 8:00 a.m. to 5:30 p.m. at **855-798-4244** to answer any eligibility or PCP questions.

PCPs will receive enrollee rosters on a monthly basis. New enrollee additions will be indicated on the report. This information changes daily and should not be used to determine enrollee eligibility. Providers must verify through the IVR system operated by DHCF that enrollees are assigned to MedStar Family Choice-District of Columbia before rendering services. Providers may also call MFC-DC's Provider Relations Service Department at **855-798-4244** to obtain a monthly enrollee roster if they do not receive one.

I. PRIMARY DENTAL CARE

All MFC-DC enrollees will have a Primary Dental Provider (PDP). DC Healthy Families enrollees have the opportunity to select a PDP when starting in the program. If one is not chosen within 10 days of enrollment, a PDP will be assigned. DC Healthcare Alliance and Immigrant Children Program enrollees are auto-assigned a PDP. MFC-DC will inform the enrollee of their right to choose their PDP and to change their PDP at any time.

J. BECOMING A MEDSTAR FAMILY CHOICE-DISTRICT OF COLUMBIA PROVIDER

MFC-DC recognizes the importance of maintaining a provider network comprised of the necessary provider types to ensure that all the covered health care benefits of our enrollees are met. Our robust network of participating providers has afforded our enrollees the convenience of seeing providers who are geographically accessible. For each of our enrollees 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 Enrollee population.

Provider Selection and Retention Process

MFC-DC's Provider Relations team will ensure its network of participating providers continue to meet the needs of our enrollees. Provider availability will be monitored through active review of: requests from Care Management, trends from out-of-network requests, trends from single case agreements, requests from Enrollee Services, GeoAccess reports showing the number and type of providers needed for recruitment and privileges at participating hospitals. Providers who express interest in joining MFC-DC may also be recruited depending on network need as well.

MFC-DC will also continue to actively monitor enrollee demographics to ensure we have the appropriate number of providers for our active enrollees. MFC-DC Provider Relations will closely review the open and closed panels of providers monthly to ensure there is no risk to access to care. Additionally, MFC-DC will review the geographic location of providers and enrollees to ensure access to care are within the accepted distance and travel time by normal means of transportation (including public transportation) and whether provider locations are accessible to enrollees with disabilities.

MFC-DC values the services provided by our participating network. In order to ensure network retention, Provider Relations will perform annual provider satisfaction surveys and identify areas for performance improvement. MFC-DC's Provider Relations team will also analyze termination reasons to understand why providers are leaving the network. Finally, MFC-DC's Provider Relations team will routinely visit provider offices to ensure providers know how to contact us for any assistance in issue resolution and to be proactive in resolution of any issues.

Initial Credentialing

All providers who are interested in joining MFC-DC are required to be screened and enrolled as District of Columbia Medicaid Provider by the Department of Health Care Finance, and must follow the Federal and District requirements regarding re-enrollment. This requirement does not require providers to render services to DC Medicaid Fee-For-Service recipients.

All providers must be credentialed in the MFC-DC network before providing covered services to MFC-DC enrollees. Providers interested in participating in the MFC-DC Provider Network should visit our website **MedStarFamilyChoice.com** or contact the Provider Relations Department at **855-798-4244** Monday through Friday 8:00 a.m. to 5:30 p.m to request contracts and an application package. If providers are participating with CAQH, providers should request the MFC-DC Provider Relations Department to send them a CAQH Data Form. Providers must authorize MFC-DC in CAQH in order for MFC-DC to access provider's application. If providers are not participating in CAQH, the provider may use the paper Uniform Credentialing/Recredentialing Provider Application. This can be obtained on the DC.gov website **CredentialingApplicationDC.com** or can be obtained by contacting Provider Relations. A completed CAQH Medical Data Sheet, Disclosure of Ownership and Control Interest form and a copy of a current malpractice insurance face sheet and a full paper application must be submitted to MFC-DC for processing. Signed participation agreements must accompany the CAQH form in order for the credentialing process to begin. Providers must also have an active DC Medicaid Fee-for-Service provider number. MFC-DC complies with NCQA standards and 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.

Providers shall not be denied participation in the MFC-DC 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 provider specializes. In addition, MFC-DC does not discriminate against providers 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.

Each provider who applies for participation within the MFC-DC 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 and a copy of a current malpractice insurance face sheet.
- An active District of Columbia Fee for Service Medicaid Provider Number (where applicable);
- Disclosure of ownership and management, business transactions and convictions of crimes, in accordance with Federal and District of Columbia regulatory requirements.
- MFC-DC only recognizes residency programs accredited by the Accreditation Council for Graduate medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the royal College of Physicians and Surgeons of Canada. Completion of residency training (internship and residency) must include a minimum of at least three years for physicians.
- Current unrestricted license to practice medicine in the jurisdiction where provider is practicing.
- Medical liability insurance coverage. Minimum liability amounts for MFC-DC 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.
- Specialist must have current, unrestricted privileges at a MFC-DC participating hospital.
- Specialists must be Board Certified, Board Eligible or Board Qualified;
- Allied Health Care Professionals must be certified in their respective specialty.
- MFC-DC requires all providers who render services to our enrollees to be credentialed, whether they bill for services directly or not, this includes nurse practitioners and physician assistants.
- Primary Care providers treating enrollees 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

MFC-DC, in accordance with state, the District of Columbia, federal regulatory authorities, credentialing authorities, and other accrediting body (NCQA, CMS, etc.), requires recredentialing of providers at least every three (3) 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 reappointment date to begin the recredentialing process. Providers must have an active District of Columbia Medicaid Fee for Service Provider Number at the time of recredentialing.

All providers are sent written notification of initial credentialing and recredentialing decisions.

Adverse Action Reporting

In accordance with appropriate Federal and District law, MFC-DC sends information on reportable events to the National Practitioner's Databank and to the District of Columbia Board of Medicine, as appropriate. All review outcomes, including actionable information are included in the provider's credentialing record.

Site Audits

A site audit is performed at initial credentialing. MFC-DC Provider Relations will work with the provider offices to schedule a time to perform the site audit. If the provider is joining an existing provider office location a site audit is not conducted. A site audit may occur more frequently if MFC-DC receives enrollee complaints regarding the office. Provider Relations also 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. Enrollees should not be seen in the new location until the site audit has been performed.

Organizational Provider (Facility) Credentialing

MFC-DC credentialing process for organizational providers (facilities) must include receipt of:

- Completed credentialing application;
- An unrestricted and current License, if applicable;
- Copy of current DEA or CDS if applicable
- Evidence of Eligibility with State and Federal Regulatory Bodies – including Medicare and Medicaid;
- Current Malpractice Face Sheet;
- A copy of Accreditation Certificate from a Recognized Accrediting Body or a copy of the Centers for Medicare and Medicaid Services (CMS) State Survey;
- If the provider is not accredited and does not have a CMS State Survey, a Site Audit will be required

For those organizational providers (facilities) who are either accredited or have had a CMS site survey, a copy of the accreditation or site survey must be submitted with the initial credentialing documentation. Additional site visits for accredited facility providers may be performed. Consistent with the District of Columbia requirements and NCQA, Organizational Providers (Facilities) are recredentialed at least every three (3) years.

K. PROVIDER TRAINING

Once the provider is credentialed with MFC-DC, the provider will receive a welcome packet which includes the effective date of the contract. The Welcome Packet includes information on accessing on-line resources for MFC-DC providers on **MedStarFamilyChoice.com**. There is a wealth of information through our Provider Website including access to our Provider Manual, Provider Updates, Provider Support and other helpful material to help you navigate what it means to be an MFC-DC network provider.

Within one month of entering the MFC-DC network, all new providers or provider groups will be offered a provider orientation and training. Provider training will include at a minimum:

- Overview of the DCHF, ICP, CASSIP, Alliance programs along with DHCF priorities
- Availability and access standards;
- Use of evidence-based guidelines, MFC-DC treatment guidelines and the definition of Medical Necessity;
- Overview of EPSDT, the periodicity schedule, compliance requirements, the Salazar Order/ Consent Decree, and subsequent court order;
- Overview of the IDEA and roles and responsibilities of the schools, the Early Intervention Program, Providers and Contractor;
- Policies and Procedures on Advance Directives;
- Fraud, Waste and Abuse and Compliance policies;
- Quality program and plan;
- Procedures for arranging referrals with other District agencies and services;
- Cultural Competency, the availability and protocols for use of interpreters for enrollees who speak limited English and other skills for effective health-related cross-cultural communication;
- Reporting requirements, including communicable disease reporting requirements;
- Privacy and Confidentiality of Protected Health Information, including 42 CFR Part 2, HIPAA Privacy and Security Rules, and the D.C. Mental Health Information Act;
- Manifestations of mental illness and alcohol and drug abuse, use of the DHCF screening tool to identify such problems, and how to make appropriate referrals for treatment services, including training at least annually for all PCPs to assist with proactive identification of Behavioral Health Service needs

As required by DHCF, HealthCheck Providers must complete the web-based HealthCheck training prior to 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. The web-based training program was developed by Georgetown University's National Center for Education in maternal and Child Health in collaboration with the District of Columbia Department of Health Care Finance, as well as MCOs in the District.

The training is available at **DCHealthCheck.net** and requires the provider's NPI to enroll. The training is free for participating MFC-DC providers. Successful completion of the training will provide up to five hours of continuing education credits.

L. PROVIDER REIMBURSEMENT

Payment is in accordance with the provider contract with MFC-DC. In accordance with the Section 1902(a)(37)(A) of the Social Security Act and D.C. Code§ 31-3132., MFC-DC 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, MFC-DC shall reimburse providers for covered services within 30 days after receipt of all reasonable and necessary documentation. MFC-DC 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 enrollees are assigned to MFC-DC before rendering services. Providers may also call MFC-DC at **855-798-4244** to obtain the enrollee's PCP.

Self-Referred and Emergency Services- DC Healthy Families

Out-of-network hospitals will be paid by MFC-DC, for all emergencies, authorized covered services and post stabilization care services provided outside of the established network. MFC-DC cannot deny payment for treatment obtained when MFC-DC's representatives instruct the enrollee to seek emergency services. MFC-DC cannot limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

MFC-DC will reimburse out-of-plan providers for the following services for enrollees enrolled in DC Healthy Families:

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

DC Healthcare Alliance enrollees 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 MFC-DC's network, adequate and timely coverage of services will be provided out of the network. MFC-DC will coordinate with out-of-network providers with respect to payment and ensure that cost of the services and transportation is no greater than it would be if the services were furnished within the network.

Second Opinions

If an enrollee requests one, MFC-DC 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 MFC-DC network we will arrange for the enrollee to obtain one outside of our network at no cost to the enrollee. Second opinions for Alliance enrollees must occur within the network.

Enrollees with Special Healthcare Needs - DC Healthy Families

Enrollees with Special Health Care Needs will be contacted directly by MFC-DC to ensure enrollment with a new provider. In the event that an enrollee with Special Health Care Needs is unable to secure a new network provider within 3 business days, MFC-DC 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 MFC-DC is able to arrange for such service from a network provider. These services will be paid for at a rate negotiated by MFC-DC and the non-network provider.

If MFC-DC denies, reduces, or terminates the services, enrollees have an appeal right, regardless of whether they are a new or established enrollee. Pending the outcome of an appeal, MFC-DC must reimburse for services provided.

M. CONTRACT TERMINATIONS

Providers should refer to their Agreement with MFC-DC regarding termination provisions. Providers who are terminated by MFC-DC will be offered appeal rights as applicable.

Primary Care Providers

To ensure, continuity of care, MFC-DC must notify enrollees within 15 days after issuance of the termination or within 30 days prior to the Primary Care Provider termination date. In addition, MFC-DC will notify DHCF in accordance with contractual requirements. The notice will provide Enrollees with information regarding the assistance in securing a new PCP, and where, and how to obtain assistance. The notice will also notify enrollees of the date the PCP's contract will terminate, arrangements for transferring Private Health Information (PHI) and future contact information for the PCP. The enrollees will be given the option of choosing a new PCP or being assigned to one. For enrollees assigned to PCP groups, the enrollees are given notice that the provider within the group has left the practice. Enrollees will remain assigned to the group unless the enrollee calls Enrollee Services to change PCPs. In some cases, enrollees 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 MFC-DC to be in compliance with the District requirements, it is imperative that providers promptly notify MFC-DC of any and all changes to the provider's practice.

Specialty Providers or Specialists

For specialists that are terminating, MFC-DC will notify enrollees 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. In addition, MFC-DC will notify DHCF in accordance with contractual requirements. The enrollee will be advised to select a new specialist provider, and to contact Enrollee Services if they require assistance. In some cases, for those enrollees in active treatment, MFC-DC and the terminating provider may agree to extend the enrollee's care under the terminating provider for a period up to 90 days. For OB/GYNs, if enrollees are in their second or third trimester continuity of care provisions may extend to the postpartum period. There are out of network limitations for DC Healthcare Alliance enrollees. The provider should contact Care Management to discuss continuity of care issues. In order for MFC-DC to be in compliance with the District requirements, it is imperative that providers promptly notify MFC-DC of any and all changes to the provider's practice.

N. CONTINUITY OF CARE

MFC-DC is responsible for providing ongoing treatments and patient care to new enrollees until an initial evaluation is completed and MFC-DC develops a new plan of care.

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

- 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 enrollees await their initial PCP visit and comprehensive assessment. Services comparable to those that the enrollee was receiving upon enrollment into MFC-DC are to be continued during this transition period.
- If, after the enrollee receives a comprehensive assessment, MFC-DC determines that a reduction in or termination of services is warranted, we will notify the enrollee of this change at least 10 days before it is implemented. This notification will tell the enrollee that he/she has the right to formally appeal to MFC-DC by calling the MedStar Family Choice-DC Appeals Department at **855-798-4244**. In addition, the notice will explain that if the enrollee files an appeal within ten days of our notification, and requests to continue receiving the services, then MFC-DC will continue to provide these services until the appeal is resolved. The provider will receive a copy of this notification.

O. SPECIALTY REFERRALS

MFC-DC 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 MFC-DC Care Management Department at **855-798-4244**. 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 enrollees, out of network services are not covered.

Section II

Provider Responsibilities

A. ROLE AND RESPONSIBILITIES OF MFC-DC PRIMARY CARE PROVIDERS

MFC-DC Primary Care Providers are responsible for managing the health care needs of their patient panel, including appropriate referrals to participating MFC-DC Specialists when medically necessary. In most cases, prior-authorization for routine referrals is not required.

MFC-DC 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 enrollee's wait time should be no more than 30 minutes, and emergency cases should be seen immediately.

The PCP is required to:

- Address the enrollee's general health needs;
- Provide periodic complete physicals and preventive medical exams
- Perform Pre-Operative physicals, history and clearance
- Perform school, sports and camp physicals
- Provide all routine injections and immunizations required in accordance with periodicity schedules. Vaccines for enrollees 18 years and younger must be obtained through the Vaccines for Children (VFC) program. Vaccines covered by the VFC program are not reimbursable by MFC-DC.
- Provide all other coordination of care, counseling, patient education, discussion with family, enrollees, paperwork, risk factor reduction interventions, and health risk assessments
- Provide or arrange coverage via answering service, 24 hours a day, 7 days a week with no charge to patients
- When ordering medications or writing prescriptions, prescribers need to reference the MFC-DC formulary and prior-authorization list as appropriate
- Treat illnesses
- Coordinate the enrollee's health care;
- Promote disease prevention and maintenance of health;
- Maintain the enrollee's health records; and
- Refer for specialty care when necessary.
- Offer hours of operation to MFC-DC enrollees that are no less in number or scope than the hours of operation offered to commercial or other Medicaid patients.

The following appointment guidelines must be followed:

1. Emergency Care: Immediately at the nearest facility
2. Urgent Care Appointments: 24 hours from request

3. Routine Primary or Specialist Care (including HealthCheck appointments that are due, IDEA services and physical exams): Within 30 days of request
4. Initial appointments to new enrollees 21 and over: Within 45 days of their enrollment date or within 30 days of request, whichever is sooner.
5. Initial appointments to new enrollees under the age of 21: Within 60 days of enrollment, or earlier if needed to comply with periodicity schedule
6. Initial assessment of pregnant and postpartum women and those requesting family planning services: 10 days from request

Other responsibilities of the PCP include:

1. When ordering medications or writing prescriptions, prescribers need to reference the MFC-DC formulary and prior-authorization list as appropriate. When ordering medications for Alliance enrollees, the Alliance formulary must be used.
2. PCPs shall notify MFC-DC at least thirty (30) days in advance of PCP reaching maximum capacity for new patients.
3. 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. Enrollees with positive screens should obtain a timely appointment from a Mental Health provider.
4. PCPs who receive appropriate training may be able to provide fluoride varnish to children who are age 3 and under. Contact Provider Relations for additional information.

B. ROLE AND RESPONSIBILITIES OF MFC-DC SPECIALTY PROVIDERS

Enrollees 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 enrollee. This must be coordinated with the MFC-DC Care Management Department prior to becoming effective.

The responsibilities of participating MFC-DC Specialty Care Physicians are as follows:

1. Address the enrollee's health needs;
2. Provide or arrange coverage via answering service, 24 hours a day, 7 days a week with no charge to patients
3. Treat illnesses
4. Maintain the enrollee's health records;
5. Refer for specialty care when necessary.
6. Provide Specialty services indicated by referral from the Primary Care Provider.
7. 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.

8. Obtain pre-authorization for procedures requiring authorization from MFC-DC Care Management Department. This also includes completing a Universal Referral Form.
9. Collect laboratory specimens in office or send enrollees 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.
10. Refer enrollees for radiology by completing the Uniform Consultation Referral Form or a prescription to a contracted radiology site.
11. Refer enrollees to contracted vendors for Durable Medical Equipment (DME) and follow MFC-DC authorization requirements.
12. Refer enrollees for Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) by completing the Uniform Referral Form to the contracted rehabilitation sites.
13. Contact the Primary Care Provider if additional services outside the specialist's scope of practice are required.
14. Comply with MFC-DC UM and Case Management for concurrent review and discharge planning.
15. Provide medical records to MFC-DC Case Management when requested.
16. When ordering medications or writing prescriptions, providers must reference the MFC-DC formulary and obtain prior-authorization as required.
17. MFC-DC providers must offer hours of operation to MFC-DC enrollees that are no less in number or scope than the hours of operation offered to commercial or other Medicaid patients.
18. The following DHCF appointment guidelines must be followed:
    - Emergency Care: Immediately at the nearest facility
    - Urgent Care Appointments: 24 hours from request
    - Routine Primary or Specialist Care (including HealthCheck appointments that are due, IDEA services and physical exams): Within 30 days of request
    - Initial appointments to new enrollees 21 and over: Within 45 days of their enrollment date or within 30 days of request, whichever is sooner.
    - Initial appointments to new enrollees under the age of 21: Within 60 days of enrollment, or earlier if needed to comply with periodicity schedule
    - Initial assessment of pregnant and postpartum women and those requesting family planning services: 10 days from request
    - Waiting time in the office may not exceed 30 minutes.

C. CLINICS AS PROVIDERS

Enrollees 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 a 2,000 total patient load of Medicaid and Alliance Enrollees.

D. ROLE AND RESPONSIBILITIES OF THE OBSTETRICAL AND GYNECOLOGICAL PROVIDER

Routine Care

Under this benefit, a female enrollee 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 enrollee elects to have her annual examination or other gynecologic-related services performed by a participating gynecologist, the protocol below must be followed:

- The enrollee must use a participating OB/GYN from the MFC-DC 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 enrollee's PCP prior to performing any diagnostic procedure that is not in the scope of routine office care.
- The OB/GYN shall contact the enrollee's PCP for all referrals for other specialty care (e.g., oncologist, neurologists, therapists, etc.).
- MFC-DC providers must offer hours of operation to MFC-DC enrollees 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.
- Waiting time in the office may not exceed 30 minutes.
- Provide or arrange coverage via answering service, 24 hours a day, 7 days a week with no charge to patients

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. MFC-DC requests that providers also send a copy of this form to the MFC-DC Care Management Department. The fax number is **202-243-6253**. MFC-DC will review the assessment and contact the Enrollee to offer appropriate services and referrals. Pregnant enrollees who are less than 28 weeks pregnant will be offered membership into the Momma and Me Program. This Program is designed to incentivize enrollees to be compliant with prenatal, postpartum, health education, and well-baby visits.

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.

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 use disorder
- Postpartum: Postpartum examination should be scheduled between four and six weeks after delivery and must be completed within 21-56 days post delivery for reimbursement. This should include a clearly documented family planning discussion (including patient's plans for birth control) and discharge back to PCP.
- Enrollees with co-morbidities may require follow up sooner than 4 weeks in accordance with ACOG recommendations.

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

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. PROVIDER DATA UPDATES

During the time a provider is contracted with MFC-DC, the provider may have changes in office locations, Tax-ID number, phone number, etc. To comply with CMS regulations regarding the accuracy of our provider directory information, MFC-DC has developed the MedStar Family Choice-DC Provider Web Portal. The MedStar Family Choice-DC Provider Web Portal serves as a quality control mechanism allowing providers to view their information in our system. Your provider information is communicated to the MFC-DC enrollees and provider community via our Find a Provider website. Other systems within MFC-DC also use this information to process authorizations, claims and issue reimbursement checks.

Provider Web Portal Services include:

- Provider and Group Changes
- Quarterly Data Validations
- Provider Web Portal User Guide

Visit the MedStar Family Choice-DC Provider Web Portal at **ProviderPortal.MedStarFamilyChoice.com** to register.

Providers without internet access, must submit changes to the MFC-DC Provider Relations department by email to **MFCDC-ProviderRelations@medstar.net** or by fax to **202-243-6254**.

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. Enrollees 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. The MedStar Provider Relations department will validate the provider demographic information on file once a quarter. All providers are required to participate in the quarterly validation process.

F. AVAILABILITY AND ACCESSIBILITY AUDITS

MFC-DC providers must ensure availability to our enrollees as outlined in this Provider Manual and pursuant to contractual obligations. Routine appointment requests must occur within 30 days (including well-child assessments, initial appointment, and preventative visits); Urgent appointments (within 24 hours of the request); and initial prenatal appointments within 10 days (OB/GYNs only).

MFC-DC utilizes a Secret Shopper program where randomly sampled providers (including primary care, OB/GYN, and specialty) will be called quarterly and asked about their availability for scheduling appointments for our enrollees. After hour calls will also be conducted to ensure there are the necessary mechanisms in place to direct enrollees during non-business hours. These results will be reviewed and tracked to proactively ensure there are no access issues for our enrollees. Any identified concern will be addressed by our Provider Relations team and the provider will be educated on the required access standards. Moreover, the provider office where there were concerns identified, will be re-audited within 6 months. Any provider failing to meet the standards again will then be placed on a corrective action plan, with their panel temporarily closed to new patients until such time they are able to meet the standards.

G. PCP PANEL CAPACITY REQUIREMENTS

MFC-DC enrollees have the option to select their primary care provider. Should they not choose one, MFC-DC will identify a primary care provider based on their previous PCP, geographic location and PCP availability. MFC-DC will closely monitor the panels of the in-network primary care providers. If it is determined that the provider has reached capacity the provider's auto-enrollment option will be turned off and panels will be closed from accepting new enrollees until it is determined they are below the appropriate threshold (500 enrollees for PCP offices). MFC-DC will routinely monitor the number / percentage of closed PCP panels to ensure all standards are met.

H. MEDICAL RECORD REQUIREMENTS

MFC-DC participating practitioners will maintain confidential medical records. At a minimum:

1. Records will be stored securely. Only authorized personnel will have access to records.
2. Electronic records will be password protected.
3. Practitioner workforce members will receive training in confidentiality, privacy, and security requirements pertaining to enrollee protected health information within 90 days of being hired and annually thereafter.
4. Prior to obtaining access to enrollee information, practitioner workforce members will sign a confidentiality statement to confirm their adherence to confidentiality, privacy, and security requirements.
5. Notification of privacy practices must be given to the patient per HIPAA requirements.

Medical Record Documentation Standard

1. All network Practitioners will maintain medical records that include at a minimum the following:
    a. The date of service
    b. History and physicals
    c. Allergies and adverse reactions
    d. Problem list
    e. Medications
    f. Documentation of clinical findings and evaluation for each visit
    g. Preventive services/risk screening and an Immunization summary sheet
    h. Chief complaint or purpose for the visit
    i. Objective findings
    j. Diagnosis or medical impression
    k. Studies ordered (lab, x-ray, etc.)
    l. Therapies administered or ordered
    m. Education provided
    n. Disposition, recommendations, instructions to the enrollee and evidence of whether there was follow-up; and
    o. Outcome of services.
2. Primary Care Practitioners records will at a minimum reflect:
    a. All services provided directly by the practitioner
    b. All ancillary services and diagnostic tests ordered by the practitioner.
    c. All diagnostic and therapeutic services for which an enrollee of MFC-DC was referred by the practitioner including home health nursing reports, specialty physician reports, consultations and letters, hospital discharge summaries, physical therapy reports, and others.
    d. Outreach efforts
    e. Organized Medical Record Keeping System and Standards for the Availability of Medical Records
3. MFC-DC expects that all network Practitioners maintain medical records that are organized and that are stored in a manner that allows for easy retrieval.

4. Practitioners must implement mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to unauthorized individuals. Medical records must be stored in a secure manner that allows access by authorized personnel only. File cabinets and other medical record storage areas should have locks. Electronic records must have secure access and passwords.

5. Medical records must be made available in accordance with applicable laws. Urgent requests will be fulfilled promptly in accordance with the clinical situation and applicable requirements. Providers are responsible for adhering to verification requirements and to the timelines for responses to medical record requests which apply in their respective jurisdiction by law and/or regulation.

6. Medical records must be retained for a duration in accordance with all applicable laws, regulations, and contract requirements.

7. Providers must adhere to laws and regulations in their jurisdiction which govern records and releases, including requirements pertinent to records on mental health services, substance use, and other sensitive classes of information.

Confidentiality and Accuracy of Enrollee Records

Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies an MFC-DC enrollee. Original medical records must be released only in accordance with federal or District laws, court orders, or subpoenas.

Providers must follow both required and voluntary provision of medical records must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations. For more information pertaining to these regulations please see: **hhs.gov/ocr/privacy/**

I. REPORTING COMMUNICABLE DISEASE

Any health care provider with reason to suspect that an enrollee has a reportable communicable disease or condition that endangers public health, or that an outbreak of a reportable communicable disease or public health-endangering condition has occurred, must submit a report to the health officer for the jurisdiction where the provider cares for the enrollee.

- The provider report must identify the disease or suspected disease and demographics on the enrollee including the name age, race, sex and address of residence, hospitalization, date of death, etc. 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 HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) within 48 hours.
  - Provide periodic reports on enrollees in treatments, and notify the HAHSTA of enrollees absent from treatment more than thirty (30) days.
- Providers must report enrollees with sexually transmitted diseases and other communicable diseases, including HIV to HAHSTA.

- 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.
- Providers must 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 DC Strong Start Early Intervention Program/Office of the State Superintendent for Education (OSSE), MFC-DC and to the DHCF enrollees 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.

J. ADVANCE DIRECTIVES

Providers are required to comply with federal and state law regarding advance directives for adult enrollees. Advance directives are written instructions relating to the provision of health care when the individual is incapacitated. The advance directive must be prominently displayed in the adult enrollee's medical record. Requirements include:

- Providing written information to adult enrollees regarding each individual's rights under District law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the enrollee's medical record, whether or not the adult enrollee has been provided the information and whether an advance directive has been executed.
- Not discriminating against an enrollee because of his or her decision to execute or not execute an advance directive and not making it a condition for the provision of care.
- Educating staff on issues related to advance directives, as well as communicating the enrollee's wishes to attending staff at hospitals or other facilities.
- Educate patients on Advance Directives (durable power of attorney and living wills).

K. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1997 (HIPAA)

To ensure the privacy and security of its enrollees' medical information, MFC-DC 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 enrollees;
- Compliance with all federal, state, and local regulations pertaining to medical records (including HIPAA, HIPAA Privacy and Security Rules, District of Columbia Mental Health Information Act and the Confidentiality of Alcohol and Drug Abuse Patient Records (Part 2);
- Secure storage of both paper and electronic medical records;
- Standards to ensure confidentiality of enrollee information;
- Release of information only to authorized staff, including those from DHCF and HHS for quality assurance and auditing purposes and;
- Reporting to MFC-DC in a timeframe required by law, breaches of the HIPAA privacy rules as it relates to MFC-DC enrollees and cooperate with MedStar Family Choice-District of Columbia in the remediation of such breaches

Providers must report privacy breaches related to MFC-DC enrollees immediately in accordance with the Provider Agreement. Providers suspecting fraud and abuse must report this immediately by calling the MFC-DC Director of Medicaid Oversight or Provider Relations at **855-798-4244**.

L. CULTURAL COMPETENCY

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

Enrollees are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental, or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. MFC-DC expects providers to treat all enrollees with dignity and respect as required by federal law including honoring enrollee's beliefs, be sensitive to cultural diversity, and foster respect for enrollee's cultural backgrounds. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs, and activities receiving federal financial assistance, such as Medicaid.

MFC-DC is committed to providing person-centric care to its enrollees. As such, MFC-DC will provide translation services upon request of an in-network provider or enrollee to ensure effective communication can occur between the enrollee and the healthcare professional and/ or treatment team.

MFC-DC will ensure Provider Cultural Competency by routinely monitoring the enrollee population compared to the provider network to identify any potential gaps in care. MFC-DC will review our enrollee data, available census data and the provider network annually to determine whether enrollees have appropriate access to providers to meet their cultural, ethnic, racial and linguistic needs. In addition, network providers will be required to meet the requirements of the Americans with Disabilities Act. If there are any identified gaps, Provider Relations will attempt to recruit providers in the geography for a more holistic and culturally competent network.

M. HEALTH LITERACY

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

MFC-DC is required to verify that Limited English Proficient (LEP) enrollees have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible for, experience delays, denials of services, receive care, services based on inaccurate or incomplete information. Providers must deliver services in a culturally effective manner to all enrollees, including those with limited English proficiency (LEP) or reading skills.

Providers who treat individuals with physical or developmental disabilities must be trained on the special communications requirements of individuals with physical disabilities. MFC-DC is for accommodating hearing-impaired enrollees who require and request a qualified interpreter. MFC-DC can delegate the financial risk and responsibility to providers, but MFC-DC is ultimately responsible for ensuring that enrollees have access to these services.

MFC-DC does provide interpreters for enrollees that require such services. MFC-DC utilizes a language line and can provide for in-office translation services when necessary. Providers may contact the Care Management department at **855-798-4244** to schedule telephonic translation services. Providers may contact Provider Relations at **855-798-4244** to coordinate in-office translation services. Requests for in-office interpreters should be requested no less than five business days before a scheduled/non-emergent appointment.

N. ACCESS TO INDIVIDUALS WITH DISABILITIES

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

O. APPOINTMENT SCHEDULING

In order to ensure that MFC-DC enrollees have every opportunity to access needed health related services PCPs must develop collaborative relationships with the following entities to bring enrollees into care:

- MedStar Family Choice-District of Columbia;
- 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 MFC-DC Enrollees

Primary care providers must offer new MFC-DC enrollees 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 enrollees desiring Family Planning Services shall be provided within ten (10) days of the Enrollee'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 enrollee, or laboratory findings indicate possible substance use disorder, you are to perform a substance use disorder screening using approved DHCF screening instrument as appropriate for the age of the enrollee.

Wellness Services for Children Under 21 Years

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

Appointments for initial EPSDT screening shall be offered to new MFC-DC enrollees within sixty days (60) of the enrollee'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 Enrollee's enrollment date, unless it is determined that the new Enrollee 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 enrollee 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 MFC-DC providers will be trained within 1 month of entering MFC-DC's network.

MFC-DC will notify MFC-DC providers when a child is known to be receiving IDEA services. MFC-DC will support these services to ensure that children's needs are met. Since MFC-DC may not always be informed by the school system of IDEA services, providers are relied upon to notify the plan when they are aware that children under their care are receiving such services.

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

EPSDT Outreach/Salazar Consent Decree

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 enrollee by mail, and by telephone.
- Notify the MFC-DC Outreach unit at **855-798-4244** for assistance with outreach as defined in the Provider Agreement. Providers can also complete the following EPDST Outreach Form and fax it to MFC-DC at **202-243-6252**.
- 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 MFC-DC 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.

Under the Salazar Consent Decree, all DC Medicaid Managed Care Primary Care providers are responsible for providing HealthCheck services to Managed Care enrollees under the age of 21 years. The providers must document any refusal of services in the enrollee's record.

Services for Pregnant and Postpartum Women

MedStar Family Choice-DC and MFC-DC 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 MFC-DC are responsible for making appropriate referrals of pregnant enrollees to publicly provided services that may improve pregnancy outcome. Additionally, pregnant women, postpartum 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. MFC-DC will direct all eligible enrollees to the WIC program (Medicaid enrollees are automatically income-eligible) and coordinate with existing WIC providers to ensure enrollees have access to the special supplemental nutrition program for women, infants and children or MFC-DC 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 enrollee 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 enrollee and submit it to DHCF and within 10 days of the initial visit.
- For pregnant enrollees under the age of 21, refer them to their PCP to have their EPSDT screening services provided.
- Reschedule appointments within 10 days for enrollees who miss prenatal appointments.
- Refer to the WIC Program.
- Refer pregnant and postpartum enrollees who are substance abusers for appropriate substance abuse assessments and treatment services.
- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.
- Instruct pregnant enrollee to notify the MCO of her pregnancy and her expected date of delivery after her initial prenatal visit.
- Instruct the pregnant enrollee to contact the MCO for assistance in choosing a PCP for the newborn prior to her eighth month of pregnancy.
- Document the pregnant enrollee's choice of pediatric provider in the medical record.

Childbirth Related Provisions

- Special rules for length of hospital stay following childbirth:
- An enrollee's length of hospital stay after childbirth is determined in accordance with the ACOG and AAP Guidelines for perinatal care.
- If an enrollee elects to be discharged earlier than the conclusion of the length of stay, a home visit must be provided.
- When an enrollee opts for early discharge from the hospital following childbirth, (before 48 hours for vaginal delivery or before 96 hours for C-section) one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are provided.
- Deliveries are not covered for DC Healthcare Alliance enrollees. These remain to be covered by DHCF.

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 postpartum care and follow-up related to a physical condition mental illness or substance use disorder;
- An evaluation to detect immediate problems of dehydration, sepsis, infection, bleeding, pain, or other adverse symptoms of the mother;
- Arrangement, coordination and follow-up health care for both the Newborn and the mother (including protocols for mothers who are under age 21 and/or who need postpartum care and/or are suspected of having a physical or mental health condition requiring further diagnosis and treatment);Care Coordination related to Early Intervention through Office of the State Superintendent of Education (OSSE), Women, Infants and Children (WIC) through DC Health, and family support services through the Department of Human Services
- (DHS), and other services; as applicable.
- Any other nursing services ordered by the referring provider
- Ongoing follow-up throughout the child's first (1st) year of life which shall include, but not limited to, additional home visiting to the Newborn and care giver(s), PCP and
- Specialist care coordination and providing additional community resources to address identified social factors.
- If an enrollee remains in the hospital for the standard length of stay following childbirth, a home visit, if prescribed by the provider, is covered.
- Unless MFC-DC 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.

P. 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 medical 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 use;
  - 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 an enrollee falls into one of the categories listed above or any condition defined as special needs, the PCP is required to contact the Clinical Operations Department.

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

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

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

- Upon the request of the enrollee or the PCP, a case manager trained as a registered nurse or a social worker will be assigned to the enrollee. The case manager will work with the enrollee and the PCP to plan the treatment and services needed. The case manager will not only help coordinate the care, but will help keep track of the health care services the enrollee receives during the year and will serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and MFC-DC 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 MFC-DC for sending enrollees to specialty care networks.
- All of the MFC-DC 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

An enrollee 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 an enrollee continues to miss appointments, MFC-DC must be informed. Within ten (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. MFC-DC will attempt to contact the enrollee 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 enrollee's PCP informing him or her of the unsuccessful contact. The Outreach Department and Case Management Department will work collaboratively to facilitate getting the enrollee into care. If the enrollee is contacted, the Wellness and Preventive Care Coordinators will assist the enrollee with rescheduling another appointment. If the enrollee is pregnant, an appointment will be made within ten (10) days, and all other appointments will be scheduled as available but within DHCF requirements.

Section III

MedStar Family Choice Outreach, Care Management and Utilization Management

A. OVERVIEW

The MFC-DC Clinical Operations Department includes Utilization Management and Case Management Services. The Utilization Management staff will review pre-authorization requests for medical services. The Case Management staff will work with providers and assist them in managing complex enrollees that require care coordination. Our Clinical Operations Department can be reached Monday through Friday 8:00 a.m. to 5:30 p.m. at **855-798-4244**. Telephone messages or faxes received after normal business hours will be responded to on the next business day.

MFC-DC also offers at no charge, health education classes on numerous health topics. Enrollees are encouraged to participate in these classes.

For enrollees with communication barriers, MFC-DC 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 our website at **MedStarFamilyChoice.com**.

B. OUTREACH SERVICES

The Outreach Department is available Monday through Friday 8:00 a.m. to 5:30 p.m. MFC-DC can be reached at **855-798-4244**. Providers may also fax MFC-DC at **202-243-6252**. Voice messages and faxes received after hours will be handled the next business day.

New Enrollees

New enrollees 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, MFC-DC Outreach will perform a three-way call between the MFC-DC Wellness and Preventive Care Coordinator, the enrollee, and the provider office to schedule an appointment on a date and time available for both the provider and enrollee. It is the responsibility of the PCP office to provide an appointment for a new enrollee in accordance with the above guidelines.

Non-Compliant Enrollees

The MFC-DC Outreach Department assists providers with required outreach attempts for preventive care and enrollee non-compliance. If providers are aware of non-compliant enrollees, providers may contact the Outreach Department. The Outreach Department performs Outreach to non-compliant enrollees in an attempt to bring enrollees into care for necessary preventive services. If transportation is a barrier for the enrollee, transportation is available by contacting Access2Care at **866-201-9974**. Transportation services are available only to Healthy Family enrollees.

Providers should use the Outreach Referral Form or the EPSDT Outreach Referral Form and fax this completed form to **202-243-6252**. If a provider continues to experience an issue with enrollee 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 an enrollee dismissal.

C. CASE MANAGEMENT

MedStar Family Choice-District of Columbia Case Management Services are provided by registered nurses and social workers. These professionals assist enrollees in the management of their complex bio-psychosocial needs. This is done by educating the enrollee, facilitating access to healthcare, and connecting the enrollee to needed resources within the community. The goal is that every enrollee has the access to the care they need and they or their caregiver, is able to self-manage their health to the fullest capacity.

MFC-DC's Case managers work closely with the provider to ensure that enrollees receive appropriate and timely medical services. Our staff may contact you to collaborate, share clinical information or to verify that services were rendered. MFC-DC's case managers will forward you the Plan of Care for any of your patients enrolled in a case management program and welcome your feedback.

Complex Case Management Services

Complex Case Management Services are available to our highest risk enrollees with complex conditions through the Catastrophic Care (Adult and Pediatric) Programs. This population includes enrollees experiencing a critical event or diagnosis that requires care coordination or extensive use of resources.

- A critical event or diagnosis includes, but is not limited to the following:
  - Amyotrophic Lateral Sclerosis (ALS)
  - Hemophilia
  - Lymphatic and Hematopoietic (blood) system disorders
  - Guillain-Barre Syndrome
  - Liver Failure
  - Burns > 20% of total body surface area
  - Hemiplegia
  - Sickle Cell Disease with Severe Crisis

- Cancer/Tumors
- Cerebrovascular Accident (Stroke)
- Osteomyelitis
- Sepsis
- Transplants
- Acute trauma with complex care coordination needs
- Complex psycho-social or behavioral needs

Comprehensive Case Management Services:

The Complex Care (Adult) and Complex Care Pediatrics Programs are designed for those enrollees who do not meet the eligibility requirements for the Catastrophic Care Program and are identified at our next highest level of risk.

- Adult enrollees with chronic conditions (Examples: Asthma, CAD, CHF, COPD, Diabetes) who are at high risk of having a disease specific inpatient admission in the next 12 months or re-admission within 30 days based on a readmission Risk Score.
- Pediatric enrollees with any of the following:
  - Diabetes
  - Asthma
  - Obesity
  - Epilepsy
  - Chronic Lung Disease
  - Cardiovascular Disease (CAD)
  - Attention Deficit Hyperactivity Disorder (ADHD)
  - Depression
  - Anxiety
  - Substance Use Disorder
  - Other Mood Disorder

Condition Care Program

The Condition Care Program is designed for adult enrollees who do not meet the requirements for the Catastrophic Care or Complex Care Programs, but require additional assistance, health education, and care coordination in managing the management of their chronic conditions(s), that include but is not limited to one of the following:

- High Risk Pregnancy
- Diabetes
- Asthma
- COPD
- Hypertension
- Cardiovascular Disease
- HIV
- Substance Use Disorder
- Social Issues/Mental Health

The aim of the Condition Care program is to promote self-management skills that prevent elevation into a higher risk level. This is accomplished by assisting your patient to better understand their chronic condition, empowering them with self-care strategies and reinforcing the mutually agreed upon treatment plan developed by you and your patient. As with any of the Case Management programs offered by MFC-DC, the Case Management Staff may contact you to request clinical information, verify services that have been rendered or to collaborate on next steps. We do appreciate your prompt response to these requests.

Services offered to MFC-DC enrollees participating in Complex Case Management Services include:

- Support from our Case Managers and other staff to ensure that your patients receive the assistance they need to facilitate appropriate services
- Educational materials, as appropriate, to understand their conditions
- Assistance in coordinating homecare services as needed for skilled care, as well as any outstanding teaching needs
- Information on community or MedStar Health events, such as health fairs or support groups that may be pertinent to their conditions

Transition Care Case Management Services

Transition Care Case Management is a service provided by MFC-DC to assist your patient if they were just discharged from the hospital. Enrollees of MFC-DC do not have to enroll; they are identified by the predictive model software embedded within the clinical software used by MFC-DC. This service is provided by staff who work closely with your patient to assist with following the discharge plan order by the hospital care team, locating providers, and scheduling follow-up appointments. This service is offered for 30 days, and if after that time your patient requires further assistance, they will be referred to one of our other case management services.

Emergent Care Case Management Services

The Emergent Care Program is facilitated by non-licensed personnel under the guidance of the manager of case management. It offers care coordination services to those enrollees who exhibit a pattern of frequent ED utilization and is designed to reduce the likelihood of return ED encounters for services that could otherwise be provided by a PCP or urgent care center. Enrollees are identified for the Emergent Care Program by the predictive model software embedded within the clinical software used by MFC-DC.

Enrollees participating in the Emergent Care Program who are found to require additional assistance upon program completion are referred for ongoing case management services as appropriate. Enrollees may also be offered in-home primary care intervention to address immediate needs, barrier analysis related to accessing care outside the ED, and assistance to re-connect care with a PCP.

Enrollee participation in any Case Management program is voluntary and enrollees have the option to stop participating at any time. If providers would like to refer an enrollee to one of these programs, please fax referral to **202-243-6253**, or call the MFC-DC Clinical Operations Department at **855-798-4244**. 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 MedStar Family Choice-DC website. Copies can also be obtained upon request by calling our Care Management Department.

D. HEALTH EDUCATION CLASSES

MFC-DC Enrollees 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 enrollees. Class schedules are sent to enrollees. 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 Enrollee Service Representatives, Provider Relations, and Wellness and Preventive Care Coordinator, Case Managers. Additionally, the educational schedule will be highlighted in the enrollee newsletter and on the MedStar Family Choice-DC website. Transportation is also offered to enrollees who attend these events.

Enrollees who wish to quit smoking are encouraged to call the DC QuitLine for immediate assistance (**1-800-QUIT-NOW**). More information about MFC-DC's stop smoking program can be obtained by calling the Outreach Department at **855-798-4244**.

Please encourage MFC-DC enrollees to take appropriate classes that would be of benefit for their particular condition or disease. Providers that refer enrollees to a health education class should document this in the enrollee's chart.

E. EPSDT EDUCATION

Primary care providers are responsible for providing written and oral explanations of EPSDT services to enrollees 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

MFC-DC enrollees with limited or no English proficiency must be assessed for translation service needs. MFC-DC utilizes a language line and can provide for in-office translation services when necessary. Providers may contact the Care Management Department **855-798-4244** to schedule telephonic translation services. Providers may contact Provider Relations **855-798-4244** to schedule in office translation services with a contracted vendor.

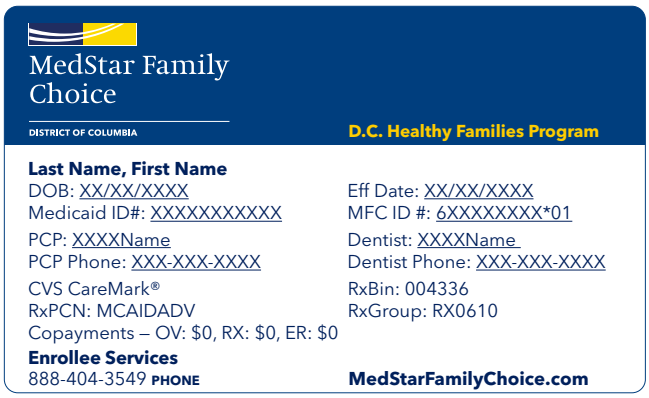
Providers shall ensure that enrollees are aware of the availability of professional interpreter services, assist in arranging for these services as necessary and ensure that the enrollees are aware that the services are free of charge. Enrollees are not encouraged to use a family member or friend for interpreter services. However, if the enrollee refuses to utilize a professional interpreter, this must be documented in the enrollee'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.

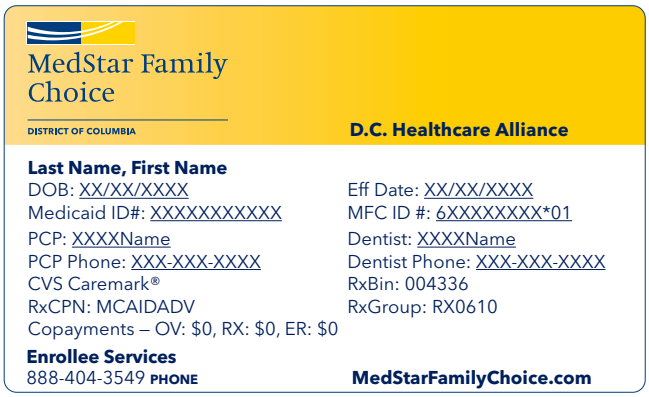
For routine appointments, providers should give at least five (5) days prior notice for an interpreter request. For urgent appointments, providers must request assistance as quickly as possible. In emergent, after hours situations the 24 hour Nurse Advice Line can be called at **855-798-3540** to help direct enrollees to the appropriate care that they need.

G. ELIGIBILITY VERIFICATION

MedStar Family Choice-DC Enrollees are provided with an identification card indicating MedStar Family Choice-District of Columbia as their chosen Managed Care Organization.



Healthy Family



Healthcare Alliance

Providers must verify eligibility through the District of Columbia IVR system prior to rendering services to MFC-DC enrollees. 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 MFC-DC at **855-798-4244** Monday through Friday 8:00 a.m. to 5:30 p.m to identify the enrollee's PCP. MFC-DC enrollees may change PCPs at any time. Enrollees can call MFC-DC Enrollee Services Monday through Friday 8:00 a.m. to 5:30 p.m at **888-404-3549** to change their PCP. PCPs may see MFC-DC enrollees even if the PCP name is not listed on the enrollee ID card. As long as the enrollee is eligible on the date of service and the PCP is participating with MFC-DC, the PCP may see the MFC-DC enrollee. However, MFC-DC does request that the PCP assist the enrollee is changing PCPs so the correct PCP is reflected on the enrollee ID card. The office should contact Enrollee Services at **888-404-3549**.

H. REFERRAL AND UTILIZATION MANAGEMENT PROCESS

Referrals

MFC-DC encourages primary care and specialty providers to work together in managing an enrollee's care. This ensures that enrollees receive the highest quality of coordinated, appropriate and enrollee-sensitive care.

Specialists will provide consultative services and treatment or procedures on enrollees based on the referral instructions from the enrollee's PCP.

The PCP should complete all sections of the Universal Consultation Referral Form when referring the enrollee to an MFC-DC specialist. The Referrals Forms to specialists should accompany enrollees at the time of their appointment. If an enrollee presents for an appointment without a Referral Form, **do not** turn the enrollee away. Attempt to contact the PCP office for a copy of the referral form and notate in the enrollee's chart if the attempt was not successful.

Referrals should be kept in the patient's chart and should not be sent to MFC-DC. Referrals do not need to be submitted with a claim.

Routine Referrals

Referrals are valid for six 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 and indicate on the form. The specialist should also copy the PCP on the notes from the consult. **Exception:** Specialists should directly refer patients for routine radiology, laboratory testing, rehabilitation, and DME services.

Laboratory Referrals

Enrollees should be referred to one of MFC-DC's in-network laboratories.

Although laboratory service centers are available, it may be more convenient for enrollees to have specimens drawn in a practitioner's office. MFC-DC will reimburse for the collection of venous blood by venipuncture when collected in a practitioner's office, however, all specimens must be sent to the appropriate in-network laboratory for processing.

Laboratory specific payment guidelines including specific laboratory services that can be performed in the clinician's office may be found on our website at **MedStarFamilyChoice.com**. The list of specific laboratory services that can be performed in a clinician's office may periodically change as CPT codes may be added to the list or modified to adhere to coding guidelines.

The most up to date information can be found on our website in the section labeled "For Providers" under the Provider Resources tab. For individuals that require genetic testing services please refer to our pre-authorization grid to ensure that no authorization needs to be given prior to the services being rendered to the enrollee.

OB/GYN Referrals

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

Radiology Referrals

MFC-DC has a network of free-standing radiology facilities throughout the service 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 **855-798-4244** 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 enrollees directly for radiology services. Enrollees 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 at **MedStarFamilyChoice.com** (click on "For Healthcare Providers" and select the Pre-authorization and Utilization Management webpage).

Referrals are not required for screening mammograms at a participating free-standing radiology facility. A list of participating radiology locations can be found on our website at **MedStarFamilyChoice.com**.

Participating orthopedic providers may perform flat film x-rays in their office (POS 11) without an authorization.

Rehabilitation Referrals

Please refer to the MedStar Family Choice-DC website for a listing of participating sites (or contact Provider Relations for a written copy).

Self-Referrals for Dental and Vision

Enrollees may ask for information regarding routine vision or dental care. No referrals are required.

Avesis will handle all routine vision services for our enrollees. However, MFC-DC will directly coordinate and manage the medical aspect of these services.

Urgent/Emergent Referrals

For patients requiring immediate services, please call MFC-DC Care Management Department at **855-798-4244** or fax the Uniform Consultation Referral Form or the MFC-DC Prior Authorization Form to **202-243-6258**.

Services Requiring Prior Authorization

In most cases, prior-authorization for routine specialty care is not required. Those services requiring prior-authorization are detailed in the most current Prior Authorization Quick Reference Guide available on our website, **MedStarFamilyChoice.com** under the Provider Resources tab. See Pharmacy section for details on medication prior authorization policies and processes.

MFC-DC reviews services at least annually to determine if they need to be added to or removed from the list of services requiring prior authorization. Our goal is to continually look to streamline this process to reduce the amount of administrative work that our participating providers are required to do prior to services being rendered to our enrollees. MFC-DC will notify providers of any changes to the list of services requiring prior authorization no less than 30 calendar days prior to the effective date of the Prior Authorization list modification. To obtain the most current list of services that require a prior authorization, please visit **MedStarFamilyChoice.com** and look in the "For Heathcare Providers" area, under "Provider Resources." Providers without internet access can call **855-798-4244** for additional assistance.

Prior Authorization Notes:

Out-of-Network care for non-Self-Referral Services always requires a prior authorization. Genetic counseling during prenatal care must be performed by the OB/GYN.

Services not Requiring Preauthorization

Procedures performed in the outpatient setting by an in-network provider at an in-network facility do not require prior authorizations.

CT Scan, MRI's and Screening Mammograms performed at participating radiology site do not require prior authorization.

Dialysis is a self-referred service and does not require prior authorization Providers are encouraged to refer enrollees to a participating facility when possible. In most cases, prior-authorization for routine specialty care is not required. Those services requiring prior-authorization are detailed in the most current Prior Authorization Quick Reference Guide available on our website, **MedStarFamilyChoice.com** under the "Provider Resources" tab.

Medically Necessary

"Medically necessary" services or benefits must be:

- Services for individuals that 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 and in accordance with generally accepted standards of medical practice, including clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Enrollee's illness, injury, disease, or physical or mental health condition.

Prior authorizations procedures

MFC-DC follows a basic pre-authorization process: An enrollee's clinician forwards clinical information and requests for services to MFC-DC by phone, fax, or infrequently by mail. Providers may contact the utilization manager on business days from 8:00 a.m. to 5:30 p.m. at **855-798-4244**. The fax number is **202-243-6258** and faxes are received 24 hours a day, seven days a week. Faxes and voice messages received after hours will be addressed the next business day. Outside of normal business hours, the voicemail message includes access to a UM nurse for urgent after-hours authorization needs.

MFC-DC does not specifically reward practitioners or other individuals for issuing denials of coverage of care. In addition, there are no financial incentives for Utilization Management (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 MFC-DC Care Management department to request a written copy. Providers may request the UM criteria utilized for a specific case by calling the MFC-DC Care Management department at **855-798-4244**.

All appropriate ICD-10/CPT/HCPCS, along with supporting clinical information must be included in requests for pre-authorization. ICD-10/CPT/HCPCS codes in the medical record must match what is being requested for authorization and what is billed to MFC-DC. Requests for authorization can be included on the Uniform Consultation Referral Form or MedStar Family Choice-District of Columbia Prior Authorization Form with clinical information attached. MFC-DCs experienced clinical staff reviews all requests for medical necessity. MFC-DC pre-authorization decisions in determining medical necessity are based on the following criteria:

- MFC-DC Protocols
- MFC-DC Pharmacy Policies and Procedures
- InterQual
- Medicare and Medicaid Guidelines
- DHCF Contract Requirements
- MFC-DC MCO benefit coverage
- MFC-DC Provider Manual
- MFC-DC Enrollee Handbooks (DCHF and DCHA)
- Food and Drug Administration (FDA) Approval
- DC Medicaid DMS/DME Program Approved List of Items
- Availability of services within the MFC-DC network
- MFC-DC Continuity of Care Policy
- Pain Management Contracts
- UM Criteria Policy
- National and International Professional Medical Society Guidelines, including but not limited to:
  - National Comprehensive Cancer Network (NCCN)
  - NCCN Biomarkers Compendium
  - National Institutes of Health
  - National Cancer Institute

- DC Medicaid Medical Laboratory and Professional Services Program Approval List of Items
- US Preventative Task Force
- In the absence of guidelines, use prevailing medical literature form studies and journals

MFC-DC 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 or for continuity reasons. Prior authorization is required. MFC-DC's utilization management decision making is based on the medical necessity of the service and the existence of MCO enrollment and coverage.

Standard non-urgent pre-service authorization decisions are completed as expeditiously as the enrollee's health condition requires and no later than 14 calendar days of receipt of the requested service. The final decision cannot take longer than 14 days, regardless whether all clinical information has been received. If the service requested is denied, the provider may contact our Care Management Department by calling **855-798-4244** to discuss the decision with the appropriate medical director.

Urgent expedited pre-service authorization decisions are completed as expeditiously as the enrollee's health condition requires and no later than 72 hours from the receipt of the request for service. For enrollees with urgent authorization needs, practitioner or a practitioner's staff member should contact MFC-DC Care Management Department at **855-798-4244**.

A limited number of services require authorization from MFC-DC Care Management Department 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 defined self-referral service or a continuity of care.

Services that are carved out to the District are subject to administrative denial since they are not the liability of MFC-DC.

Period of Preauthorization

Prior authorization numbers are valid for the date(s) of service authorized, a range of dates, or for a period not to exceed the date of service authorized. MFC-DC should be notified for any change in planned date of service or range of service dates if the proposed care will no longer match the authorization. The enrollee must be eligible for Medicaid and enrolled in MFC-DC on each date of service.

Inpatient Admissions and Concurrent Review

Initial Request for Inpatient Authorization

In situations where MFC-DC receives requests for inpatient authorization accompanied by clinical review, MFC-DC will communicate a decision within 72 hours (three calendar days) of receipt of your request.

Concurrent Review

MFC-DC utilizes the following criteria to assist in the process to determine medical necessity for concurrent review decisions:

- InterQual
- Medicare and Medicaid Guidelines
- District of Columbia Health Care Finance contract and guidelines
- MFC-DC benefit coverage
- Availability of services within the MFC-DC network
- MFC-DC UM Criteria Policy

MFC-DC reviews clinical documentation for timeliness of care and appropriate level of care. Clinical denial determinations may be issued by our Medical Directors 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 MFC-DC 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 MFC-DC receives requests for additional urgent concurrent care that is accompanied by clinical review, MFC-DC will communicate a decision within 72 hours (three calendar days) of receipt of your request.

In situations where MFC-DC receives requests for additional urgent concurrent care that is NOT accompanied by clinical review it is MFC-DC's process to make at least one attempt to request the outstanding clinical information. Clinical not received within 72 hours (three calendar days) of the authorization request will be subject to denial.

Services that are carved out to the District of Columbia are subject to administrative denial since they are not the liability of MFC-DC.

Emergency Care

In accordance with the Emergency Medical Treatment & Labor Act (EMTALA), MFC-DC will pay claims for all medical screening examinations when the request is made by an enrollee for examination or treatment for an emergency medical condition, including active labor. MFC-DC 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, MFC-DC 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 MFC-DC autopay diagnosis list is included on the MFC-DC website. If the diagnosis is not listed on the auto-pay list, MFC-DC 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.

Services that are carved out to the District are subject to administrative denial since they are not the liability of the MCO.

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, MFC-DC will assign a prior authorization number, which refers to and documents the approval. MFC-DC sends written notice of adverse determination to the out-of-network provider within the time frames appropriate for the type of request. Occasionally, an enrollee may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. MFC-DC makes such decisions on a case-by-case basis.

I. PHARMACY

MFC-DC is responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the DCHF and Alliance programs.

Formulary

The MFC-DC Pharmacy and Therapeutics (P&T) Committee is responsible for the content of the MFC-DC and Alliance formularies and pharmacy policies. The drugs have been selected to provide the most clinically appropriate and cost-effective medications for our enrollees. It meets frequently during the year and reviews the entire formulary annually. Formulary updates are posted to the MFC-DC website on a quarterly basis and updates are posted following each P & T Committee meeting. The formulary and updates can be downloaded from the website as searchable PDF documents. Paper copies are available upon request. Providers may request the addition of a medication to the formulary by contacting MFC-DC Pharmacy Director at **855-798-4244**. Requests must include the drug name, rationale for inclusion on the formulary, role in therapy, and medications that may be replaced by the addition.

Healthy Families vs Alliance Formularies

The medications on the MFC-DC and the pharmacy procedures will apply to both coverage groups. One notable **exception** is medications for treating HIV/AIDS. For enrollees of Healthy Families, these medications are covered by the District and can be filled at any pharmacy in the MFC-DC network. For enrollees of the Alliance plan, these medications are supplied by the AIDS Drug Assistance Program (ADAP) and enrollees must fill the prescription at an ADAP pharmacy. The list of current ADAP pharmacies is maintained by the District on its website.

The following are not covered by the MCO:

- Prescriptions or injections for central nervous system stimulants and anorectic agents when used for controlling weight;
- Medications prescribed for cosmetic indications and hair regrowth
- Medications for hypoactive sexual dysfunction disorder and erectile dysfunction; and
- Ovulation stimulants for infertility

Pharmacy Network

MFC-DCcontracts with CVS Caremark® to provide the following services: pharmacy network contracting, safety including drug-drug interactions, drug-disease interactions and other safety edits, FDA and voluntary manufacturer drug recalls and network Point-of-Sale (POS) claim processing. The MFC-DC pharmacy network is robust and includes many large chains (CVS, Walmart, Giant, Rite Aide and others) and a number of independent pharmacies in the District. Pharmacies in the network can be found using the "Find a Provider" function on the MFC-DC website. Enrollees must use an in network pharmacy (except for Alliance enrollees for HIV/AIDS prescriptions who must use an ADAP pharmacy).

Prescription Copays

There are no co-pays for children under 21, pregnant women and for family planning. Currently, MFC-DC does not assess any pharmacy co-pays.

Over- the-Counter Products

MFC-DC covers many over the counter medications. The MFC-DC Formulary lists the types of over-the-counter medications that are covered. In most cases the "house brand" will be dispensed. In order for an MFC-DC enrollee to get an over-the-counter medication covered by MFC-DC, the provider must call or electronically send a prescription to the pharmacy or handwrite a prescription for the enrollee to take to the pharmacy. Refills are permitted. MFC-DC will not pay for over-the-counter medications without a prescription. The only exception to this rule is for emergency contraception ((e.g. Plan B and others) and latex condoms). Neither of these over-the-counter products require a prescription to be covered by MFC-DC. For specific questions, providers may contact our Care Management Department at **855-798-4244**.

Prescription and Drug Formulary

MFC-DC maintains a closed formulary. Check the current MFC-DC formulary before writing a prescription for either prescription or over-the-counter drugs. To do so, go to **MedStarFamilyChoice.com/For-District-of-Columbia-Providers/Pharmacy** and select the link for MedStar Family Choice-DC Formulary. MFC-DC enrollees must have their prescriptions filled at a network pharmacy. For HIV/AIDS medications, DCHF enrollees will have their prescriptions covered by DHCF. For

Alliance plan enrollees, HIV/AIDS medications are covered by ADAP and must be filled at an ADAP pharmacy.

Non-Formulary Requests

Non-formulary medications can be filled for an emergency 72-hour supply with an override by the pharmacist. If a prescriber believes that a non-formulary drug is medically indicated long term, the prescriber should submit a Non-Formulary Request with the appropriate supporting clinical documentation. Forms and details maybe found on the MFC-DC website in the Pharmacy section.

Step Therapy and Quantity Limits

For the most current information regarding medications requiring step therapy and quantity limits, please go to the Pharmacy tab under the Providers section of **MedStarFamilyChoice.com**.

Prior Authorization Process

MFC-DC pays for a wide variety of medications, as outlined in our MFC-DC Formulary. Some formulary medications require prior authorization (PA). A full list of these medications can be found in the Formulary and in the PA Table. Both of these documents are available on the website in the Provider Pharmacy section. To do so, go to **MedStarFamilyChoice.com/For-District-of-Columbia-Providers/Pharmacy** and select the link for MedStar Family Choice-DC Formulary or the Prior Authorization Table. The PA Table offers detailed information on the criteria for each medication, special MFC-DC instructions, links to forms and other useful tools.

- All non-formulary medications require PA after an emergency 72-hour supply is filled if the medication is to be continued beyond 3 days
- Brand medications (when a generic is available) require PA.
- Medications requiring Step Therapy when there is no evidence of a prescription for the first line medication require PA.
- Early refills (e.g. for lost medication, early refills, travel supplies) require PA.
- All long acting narcotics, narcotic doses in excess of 90ME per day, and methadone for pain with an exclusion for certain diagnoses require PA
- Prescriptions for narcotics for more than a 7-day supply for opioid naïve enrollees will require PA after January 1, 2021.
- Medications to treat Hepatitis C in accordance with DHCF guidelines require PA.

Please note that early refills for opioids or any other controlled dangerous substances are not permitted unless the patient has cancer related pain, is in hospice, receiving palliative care, or has sickle cell.

Providers may submit a pharmacy PA request to MFC-DC. The request must include clinical documentation that supports the medical need for that specific medication. All PA requests are either approved by a pre-certification nurse or are reviewed further by a Medical Director prior to a final decision. MFC-DC does not guarantee coverage of medications that are outside the guidelines set forth in this manual. Physicians may call MFC-DC at **855-798-4244**, or fax requests to **202-243-6258**.

Practitioners are encouraged to review the PA Table and submit full clinical with the primary submission. Failure to submit clinical documentation is the most frequent reason for the denial

of a request.

Prior Authorization requests shall be acknowledged within twenty-four (24) hours of receipt, all decisions and notification of that decision shall be determined within seventy-two (72) hours of PA request.

A seventy-two (72) hour supply of a covered outpatient drug shall be dispensed in an emergency situation. MFC-DC may extend the seventy-two (72) hour time period by up to fourteen (14) days if the Enrollee requests an extension, or if the

MFC-DC justifies to DHCF a need for additional information and how the extension is in the Enrollee's interest. If the service is denied, MFC-DC will notify the prescriber and the enrollee in writing of the denial.

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 by calling **855-798-4244**.

Emergency Authorizations

MFC-DC maintains an after-hours on call system for emergency pharmacy authorizations. This system should be used judiciously for circumstances where a delay to obtain a medication would create a risk to the enrollee's health and no formulary alternative is available. The contact information for the on-call person can be accessed after hours by calling the main contact number **855-798-4244** and following the prompts.

Prescription Limits

Medications are generally limited to a 30-day supply or a single course of treatment if less than 30 days, with refills up to 12 months. Some maintenance medications for chronic conditions can be written for 90 days plus refills. Practitioners are encouraged to write for 90 days when available to improve patient adherence. A full listing of medications available with a 90-day supply can be found at **MedStarFamilyChoice.com/For-District-of-Columbia-Providers/Pharmacy** and select the link for 90-DAY Prescriptions – Retail AND Mail Order.

Mail Order Prescriptions and 90 Day Retail

We cannot require an enrollee to use mail-order, but we do offer mail-order pharmacy services for certain drugs. MFC-DC covers a 90-day supply of most chronic medications at retail pharmacies (some of which provide home delivery). To start the process, providers can send a prescription to the retail pharmacy for a 90-day supply. A full listing of medications available with a 90-day supply can be found at **MedStarFamilyChoice.com/For-District-of-Columbia-Providers/Pharmacy** and select the link for 90-DAY Prescriptions – Retail AND Mail Order.

MFC-DC enrollees can also sign up for mail order pharmacy for chronic medications. A 90-day supply will be provided to enrollees using mail order services. To start the process, prescribers may call CVS Caremark Mail Service Pharmacy™ at **800-996-5772** or they may submit a prescription to the CVS Caremark Mail Service Pharmacy™. A full listing of medications available with a 90-day supply from mail order can be found at **MedStarFamilyChoice.com/For-District-of-Columbia-Providers/Pharmacy**

and select the link for 90-DAY Prescriptions – Retail AND Mail Order.

Specialty Pharmacy Services

For specialty pharmacy services, MFC-DC contracts with CVS Caremark®, but it is not an exclusive supplier. MFC-DC is responsible for formulary development, drug utilization review, and prior authorization. MFC-DC's drug utilization review program is subject to review and approval by DHCF. Prescribers should be aware that many of the Specialty medications required prior authorization and that a PA is required regardless of the pharmacy used to fulfil the prescription.

District of Columbia - Prescription Drug Monitoring Program (PDMP)

MFC-DC reminds all prescribers of controlled substances (Schedule II, III, IV and V and products containing butalbitol and cyclobenzaprine) that they are required to register with the DC PDMP and while not required, we strongly encourage our practitioners to consult the DC PDMP when prescribing controlled substances for safety reasons and to help curb the opioid crisis.

Vaccines at the Pharmacy: Adult enrollees of DCHF and Alliance may receive CDC/ACIP recommended immunizations for vaccine preventable conditions at any network pharmacy offering the service. A prescription will be required by the pharmacist to administer the vaccines (except influenza) unless there is a practitioner's standing order in place. Children (0-17) should receive their vaccinations at the PCP office with supply from the Vaccines for Children Program and cannot receive immunizations at the pharmacy.

Special Note: During the declared public health state of emergency, children as young as age 3 can receive any ACIP approved / CDC recommended vaccine from a participating pharmacist. A qualified pharmacist may order the vaccine and may bill MFC-DC through the Caremark Pharmacy software system as they would any other vaccine they administer. This note will sunset once we are beyond the public health emergency.

Family Planning

MFC-DC allows enrollees to receive up to a twelve (12) month supply of covered contraceptives with a single prescription from the prescribing practitioner at participating pharmacies.

Condoms are available on the Over-the-Counter Formulary without a prescription.

Emergency Contraception – PlanB and similar products - are available without a prescription or age limitation on the Over-the-Counter Formulary.

LARCs – Long acting reversible contraceptives can be ordered from the Caremark Specialty Pharmacy for practitioners who do not wish to "buy and bill."

Section IV.
Claims

A. CLAIMS

Submitting Claims

All claims for services rendered must be submitted within 365 days from the date of service or discharge date for inpatient admissions and must include all the mandatory information outlined in the District of Columbia FFS program. In addition, all codes billed must be supported by appropriate medical records. All claims submitted must be on a CMS-1500 or UB-04 form. MFC-DC follows the CMS, National Correct Coding Initiative (NUCC) when adjudicating claims.

Electronic Claims Submission (EDI)

Medstar Family Choice-District of Columbia encourages all providers to submit claims electronically. Providers interested in electronic claim filing may contact their software vendor for more information.

EDI Payer ID: DCMED

Providers not using a clearinghouse, can submit professional claims online via the web portal. The MFC-DC website has more information regarding this process. Or, providers may contact the Claims Department at **800-261-3371** for more information.

Paper Claims Submission

Paper claims should be sent to the following address:

MedStar Family Choice-DC
DC Claims Processing Center
P.O. Box 1624
Milwaukee, WI 53201
Phone: **800-261-3371** (Monday through Friday 8:00 a.m. to 5:30 p.m)

Clean claims will be paid within 30 days of receipt, in accordance with District of Columbia Prompt Payment Act 2002. To inquire about claims status, please contact the MFC-DC claims department at **800-261-3371**. Providers may also register to check claims status on-line by contacting the claims department.

Denied claims are adjudicated in the claims system but do not meet requirements for payment. Providers will receive an Explanation of Payment explaining why the claim is denied. Claims originally denied must be corrected and resubmitted **as a corrected claim** (Set Claim Frequency Code correctly and send the original claim number) within 365 days from the original date of service.

Rejected claims are missing critical data which prevents the claim from being accepted into the claims system. Rejected claims are returned to the provider. The claims must be resubmitted with all the required data elements within 365 days from the original date of service.

Prompt Payment Act of 2002

MFC-DC shall pay all clean claims within 30 days after the receipt in accordance with the provisions of District of Columbia Prompt Payment Act of 2002. A clean claim is a claim that has no material defect or impropriety, including any lack of reasonably required substantiating documentation which may prevent timely payment being made on the claim.

In the event clean claims are not paid within 30 days of receipt, and MFC-DC does not notify the provider within said 30 days of any missing information required to pay the claim, MFC-DC will implement measures to determine and pay interest penalties in accordance with the provisions of the Prompt Payment Act of 2002 as follows:

- One and a half percent (1.5%) from the 31st day through the 60th day;
- Two percent (2%) from the 61st day through the 120th day; and,
- Two and one half percent (2.5%) after the 120th day.

Claims for Nurse Practitioners and Physician Assistants

Claims for Nurse Practitioners and Physician Advisors should be billed to MFC-DC under the NP's or PA's name.

Billing Inquiries

To obtain information on enrollee eligibility, benefits, PCP assignment, check the status of your claims, or to discuss the outcome of your claim, please call our Provider Services department at **800-261-3371**. Provider Services is available Monday through Friday 8:00 a.m. to 5:30 p.m.

Online Claims Look Up/Registration

The MFC-DC claims look up website allows providers to check claims status online 24/7. To check claims status, providers must go to **MedStarFamilyChoice.com**, select "For Healthcare Providers" and then click on "Access Claim Portal" under the image rotator. This website allows providers to sign in as a returning user or register as a new user.

In addition to the initial master account holder registration, providers may also set up subaccounts for additional users in their office. Subaccounts will allow multiple users to share the same web portal access without sharing the same username and password. The employee who is registered as the master account will be responsible for activating and deactivating employee logins. All identifying information needed for registration must exactly match the information in our database. Therefore, we recommend that offices have a copy of an EOB to refer to for accurate data input of Provider Name, ID, and address information.

Directions for registering as a new user:

Go to **MedStarFamilyChoice.com**, click on Healthcare Providers under District of Columbia Healthy Families, and then "Check Claim Status" under the Claims menu." Then click on "Register for access here."

- Locate and refer to a current EOB to input: provider name, ID, and address information. At this time, users will have the option to register as a:

- **Facility** (This option allows access to provider information associated with that medical facility, i.e.: users will only be able to view facility charges.)
- **Payee** (This option allows access to all providers and locations associated with the payee. This is the recommended option if offices wish to view all professional claims billed from multiple office locations, as well as professional charges related to facilities that are associated with the payee's information.)
- **Location** (This option allows access to provider information for one physical location or clinic. Each location will need to be registered separately.)
- **Provider** (This option allows access to only their information, i.e.: the provider's name used for the initial registration.)

After registration is complete, users can set up subaccounts for other employees.

To set up subaccounts:

Click on the "Setup > Subaccounts" tab

- Click "Create New Subaccount" In the Create Subaccount window, enter the name and email address of the new user. (System-generated messages, such as password reset messages, are sent to the email address that you enter for this user. Users can change their name and email address later on the "My Profile" tab, once they log in.)
- Enter an initial user name and password for the user. (Users can change their passwords later on the "Change Password" tab, once they log in.)
- Click "Save." The new account is created and added to the Subaccounts tab, where it can be edited, locked, or unlocked. (The subaccount user has the same web portal access as its master account, including access to patient rosters, billed amount lists, and attached documents.)
- For additional help, providers can contact Provider Portal Support at **844-275-8756** to request assistance.

Claims Disputes and Appeals

Claims Payment Dispute

The Claims Department will accept correspondence in the form of a Claims Payment Dispute form. MedStar Family Choice-DC has developed a new form for your convenience. This form contains all of the information that is required to process your request. Please complete the form in its entirety and mail or email the form to the address listed on the Claims Payment Dispute form. Providers must use the Claims

Payment Dispute form for all payment disputes or your request will not be processed.

Copies of this form are available on the MedStar Family Choice-DC website, **MedStarFamilyChoice.com** in the For Healthcare Providers area under the Claims, Appeals, and Grievances section.

Providers must use the Claims Payment Dispute form for all payment disputes, or your request will not be processed. Providers have 90 business days from date of the denial.

Formal Appeal Process

MedStar Family Choice-DC will accept appeal requests in writing within applicable time frames using the Clinical/Medical Necessity or Administrative Appeal Form from the website. Appeal requests must include a clearly expressed request for the appeal or re-evaluation. The request must include the reason and supporting documentation as to why the Adverse Action (denial) was believed to have been issued incorrectly.

MedStar Family Choice-DC will send a letter to confirm the appeal within 2 business days of receipt of the appeal request. MedStar Family Choice-DC will make a decision within 30 days from the date of the appeal and send a letter with the decision.

Providers acting on their own behalf are defined as those who dispute Adverse Actions when the service has already been provided to the enrollee and there is no enrollee financial liability. First level appeals must be submitted in writing within 90 business days from the date of the explanation of benefits (EOB) / denial notice. The appeal must outline reasons for the appeal with all necessary documentation including a copy of the claim and the EOB, when applicable. Appeal requests for medical necessity decisions must include supporting clinical/medical documentation.

A provider appeal must include a clearly expressed reason for re-evaluation, with an explanation as to why the denial was believed to have been issued incorrectly. An acknowledgement of receipt of the appeal (first and second level) will occur within five business days of receipt.

Second level appeals must be submitted within 30 calendar days of the first level appeal notification letter. The second level appeal is the final level of appeal. MedStar Family Choice-DC will respond within 30 calendar days of receipt of the second level appeal. Please use the Clinical/Medical Necessity or Administrative Appeal Form and mail the written request with all supporting documentation, such as clinical/medical documentation.

Overpayments - Refunds

If a provider receives an overpayment for a claim, please submit the refund using the Overpayment/Refund Form located on our website, **MedStarFamilyChoice.com**; then send the refund along with a copy of the Remittance Advice identifying the overpayment to the address below:

MedStar Family Choice-District of Columbia
DC Overpayments/Refunds
P.O. Box 1624
Milwaukee, WI 53201

Overpayments shall be returned to MFC-DC within sixty (60) calendar days after the date on which the overpayment was identified. The provider should also provide the reason for the overpayment.

ER Auto-Pay List

DC Healthy Families

The MFC-DC website contains the most up to date ER Auto-pay list. Claims for emergency services with an ICD-10-CM diagnosis code on the auto-pay list in the primary position will be paid without further documentation. MFC-DC 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 or downloading from the MFC-DC website.

DC Healthcare Alliance

The DHCF website contains the most up to date ICD-10 code list for Emergency Medicaid for DC Healthcare Alliance claims. Emergency room claims that include a diagnosis on this list in the primary position must be submitted to DHCF for payment. This would include emergency room visits that become inpatient admissions.

Professional payments for these encounters for Alliance enrollees should also be submitted to the DHCF for payment.

Balance Billing of Enrollees

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

MFC-DC recommends calling the Care Management Department to verify that the service is not covered before rendering the service.

Section V
Benefits and Services

A. OVERVIEW

MFC-DC 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. The services shall be in an amount, duration, and scope that is no less than the amount, duration and scope for the same services furnished to beneficiaries through a Fee For Service arrangement except as noted below and excluded by DHCF

An MFC-DC PCP serves as the entry point for access to health care services. The PCP is responsible for providing enrollees with medically necessary covered services, or for referring an enrollee to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned enrollee.

An enrollee has the right to access certain services without prior referral or authorization by a PCP. This applies to specified self-referred services and emergency services. MFC-DC is responsible for reimbursing out-of-plan providers who have furnished these services to our enrollees.

Only benefits and services that are medically necessary are covered.

B. MEDICAID COVERED BENEFITS AND SERVICES FOR DC HEALTHY FAMILIES

MFC-DC provides all Medicaid Covered Services defined below subject to any limitations outlined in federal or District regulations.

- Emergency Services
- Post-Stabilization Services
- Physician Services
- Laboratory and X-ray services
- Inpatient hospital services
- Outpatient hospital services other than services in an institution for mental diseases.
- Adult wellness services
- Women's wellness services
- Screenings consistent with US Preventive Services Task Force A and B recommendations
- Tobacco cessation
- Immunizations as recommended by the Advisory Committee on Immunization Practices
- Federally Qualified Health Centers
- Early Periodic Screening and Diagnosis and Treatment (EPSDT) services as described later in this section
- Mental Health and Inpatient Substance Use Disorder Treatment as described later in this section

- Dental services as described later in this section
- Substance Use Disorder screening and behavioral counseling as described later in this section
- Prescription drugs
- Family planning services and supplies for individuals of child-bearing age
- Pregnancy related services
- Nurse Midwife services
- Routine screening for sexually transmitted diseases
- HIV/AIDS screening, testing and counseling
- Podiatrist services
- Physical therapy services
- Occupational therapy services
- Hearing services, including diagnosis and treatment of conditions related to hearing and hearing aids
- Speech therapy services
- Durable Medical Equipment
- Diet and behavioral counseling
- Prosthetic devices
- Eyeglasses (limited to one complete pair in a twenty-four month period except when lost or when prescription has changed more than one-half diopter)
- Tuberculosis-related services
- Home Health services
- Private duty nursing services
- Personal care services
- Nursing facility services for individuals age twenty-one or older (other than IMD) up to ninety (90) consecutive days
- Hospice care
- Transportation services
- Gender Reassignment Surgery/Services, as described by DHCF policy

Children's Health Services- Covered Services (Including Immigrant Children Program Beneficiaries)

For enrollees under 21 years, medically necessary is defined in the following manner:

- Periodic and interperiodic EPSDT screening services, which include
  - Periodic and interperiodic assessments in intervals defined under the District of Columbia Health Check Periodicity Schedule and upon request by DHCF
  - Comprehensive health and developmental history
  - Unclothed physical exam

  - An immunization recommend by the Advisory Committee on Immunization Practices (Vaccines must be obtained through the Vaccines for Children program)
  - Laboratory tests (including blood lead levels)
  - Health education and anticipatory guidance
  - Vision screening services in intervals defined under the District of Columbia Health Check Periodicity Schedule
  - Hearing screening services in intervals defined under the District of Columbia Health Check Periodicity Schedule
  - Dental screening services in intervals defined by the District of Columbia Dental Periodicity Schedule. (Includes up to 4 applications of fluoride varnish per year per DHCF guidelines.)
  - Mental health and substance use disorder screening services in intervals defined under the District of Columbia Health Check Periodicity Schedule

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

Individuals with Disabilities Education Act (IDEA) Covered Services

- All Medically Necessary services under the 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

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 enrollees under age 21 in foster care or out -of-home placements.

Covered Behavioral Health Services

MFC-DC will cover the following services:

- Care Coordination, Case Management and Transportation for Enrollees receiving the following services from DBH:
  - Community-Based Interventions;
  - Multi-Systemic Therapy (MST):
  - Assertive Community Treatment (ACT);
  - Community Support;
  - Recovery Support Services;
  - Vocational Supported Employment;
  - Clubhouse Services
- Services furnished by a network of mental health care Providers, including:
  - Physician and mid-level visits, including:
    - Diagnostic and Assessment Services;
    - Individual counseling;
    - Group counseling;
    - Family counseling;
    - FQHC services and
    - Medication/Somatic Treatment.
- Crisis services, excluding beneficiaries actively receiving services in a DBH certified entity.
- Inpatient Hospitalization and Emergency Department services.
- Case management services, for individuals identified by the Department of Behavioral Health (DBH) 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 IEP or IFSP during holidays, school vacations or sick days from school.
- Inpatient Detoxification
- Outpatient Alcohol and Drug Abuse Treatment
- Services provided to MCO- enrolled students in school settings to the extent that the following requirements are met:
  - The provider has a Sliding Fee Schedule for billing for children and youth without an IEP;
  - The Provider is credentialed as a network provider by MFC-DC;
  - The Provider has an office in the school and provides services in that office; and
  - The Provider bills the MCO for the services using the codes provided by DHCF.

Dental Services

Medicaid covered services are listed below. Medical necessity, and pre-authorization and other treatment limitations defined by the DHCF Medicaid program may apply. Providers should contact Avesis at **844-391-6678** for specifics related to benefit limitations.

- One general dental examination and cleaning once every six months
- Complete series of x-rays once every three years
- Oral Prophylaxis once every six months
- Reline or rebase of remove denture limited to two in five years
- Surgical services and extractions
- Emergency care
- Root canal treatment
- Fillings
- Palliative treatment
- Sealant application
- Removable partial and complete dentures
- Dental Implants
- Removal of Impacted Teeth
- Crowns
- Orthodontia
- Inpatient hospitalization for dental service
- Elective surgical procedures requiring general anesthesia
- Additional x-rays
- Removable partial prosthesis
- Initial placement or replacement of a removable prosthesis
- Periodontal scaling and root planning

Excluded Medicaid Services

- Non-covered services
- Service is in amount, duration and scope in excess of benefit limitations
- Service is not Medically Necessary
- Excluded prescription drugs
- Inpatient transplantation surgery; MCO covers only pre and post costs of the transplant surgery
- Cosmetic surgery
- Sterilization procedure under the age of twenty-one (21) years
- Abortion that does meet federal regulations
- Service is covered by the District but not the responsibility of the MCO
- Experimental treatment
- Services that are part of a clinical trial protocol (associated services may be covered--contact MFC-DC for guidance)

C. COVERED SERVICES FOR DC HEALTHCARE ALLIANCE

The coverage furnished to Alliance enrollees is similar to the coverage enrollees would receive if they were receiving care through Medicaid. Covered services include primary and specialty physician services when Medically Necessary to diagnosis, treat illness injury and conditions. Limitations to covered services are defined by the District of Columbia Department of Health Care Finance. A listing of Alliance Covered Services which shall include, but not be limited to the services listed below.

- Primary care services
- Specialist services
- Outpatient hospital services
- Inpatient services that do not meet the requirement for admission due to an Emergency Medical Condition
- Adult wellness services, furnished in accordance with the scheduling and content recommendations of the United States Preventive Services Task Force , including immunizations recommended by the Advisory Committee on Immunization Practices
- Pregnancy care
- Urgent care services
- Screening and stabilization of Emergency Medical Conditions when furnished by a health care provider or hospital within the MFC-DC network and within the District.
- Outpatient prescription drugs
- Rehabilitation services when pre-authorized as medically necessary
- Home health care services
- Adult dental services for individuals ages twenty-one (21) and older, up to $1000 annually
  - Dental exams every six (6) months;
  - Simple and complex surgical extractions;
  - Emergency care;
  - Fillings;
  - Cleaning and fluoride treatments every six (6) months;
  - Space maintainers (partial dentures) when Medically Necessary;
  - X-rays;
  - Dentures (one new set every five (5) years) and denture repair; and
  - Oral surgery
- Emergency transportation services
- Physical therapy, occupational therapy, and speech therapy
- Nursing facility services for the first 30 days
- Dialysis services

Coverage Exclusions under the Alliance Program

- Screening and stabilization services for Emergency Medical Conditions, provided outside the District or described in DHCF Policy;
- Covered services provided outside of the MFC-DC network
- Services furnished in schools;
- Services and supplies related to surgery and treatment for temporal mandibular joint problems (TMJ);
- 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 (Covered by DHCF)
- Non-emergency transportation services; and
- Mental health and substance abuse services (covered by DC Dept Behavioral Health).

D. COVERAGE OF INPATIENT SERVICES AT THE TIME OF ENROLLMENT and DISENROLLMENT

MFC-DC 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 enrollee's enrollment with MFC-DC.

MFC-DC shall be responsible for the payment of claims for Covered Services during an entire inpatient or hospital stay when an enrollee's discharge is subsequent to the enrollee's disenrollment from MCO.

E. BEHAVIORAL HEALTH SERVICES

MFC-DC has contracted with Magellan Health to provide the covered behavioral health services available to MFC-DC enrollees enrolled in DC Healthy Families. Providers wishing to provide these services to MFC-DC enrollees must contact Magellan Health to become a participating provider and to obtain information referral and authorization guidelines at **800-777-5327**.

The only behavioral health services covered for DC Healthcare Alliance enrollees are those provided in a hospital for life threatening withdrawal from alcohol or narcotic drugs.

F. DENTAL AND VISION SERVICES

Dental and vision services are provided to enrollees through Avesis. Enrollees can go to a dentist or routine vision provider without a referral. Please note that medical vision services are coordinated and managed by MFC-DC. Providers who are interested in providing covered dental or vision services to MFC-DC enrollees must contract directly with Avesis at **844-391-6678**.

G. NURSE ADVICE LINE

MFC-DC has a 24 hour/7 days a week nurse advice line available to enrollees. While this does not take the place of the provider having 24/7 availability (coverage), it is another opportunity for enrollees to discuss health concerns with a clinician. Enrollees can call **855-798-3540** to reach the Nurse Advice Line.

H. TRANSPORTATION-DC Healthy Families and ICP Only

Providers may contact MFC-DC **866-201-9974** to assist MFC-DC enrollees in accessing non-emergency transportation services. Non-emergency transportation will be provided by MFC-DC through our partnership with Access2Care. MFC-DC will make reasonable efforts to accommodate logistical and scheduling concerns of the provider and enrollees. MFC-DC 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.

MFC-DC will provide public transportation, Smart Trip Cards, wheelchair vans, and ambulances. The type of transportation provided will depend on the medical need of the enrollee.

I. TELEMEDICINE

MFC-DC will cover and reimburse healthcare services delivered through Telemedicine in accordance with District regulations.

J. HEALTH CARE ACQUIRED CONDITIONS (HCAC)

MFC-DC will not reimburse providers for procedures relating to the following Health Care Acquired Conditions (HCAC), identified in the Affordable Care Act of20 I 0, 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 Surge1y for Obesity
- Deep Vein Thrombosis and Pulmonary Embolism following Certain
- Orthopedic Procedures except for Pediatric (individuals under the age of 21 years)
- Obstetric Populations

K. NEVER EVENTS

MFC-DC 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
- Wrong surgical procedure performed on a Patient

Section VI

DHCF Quality Improvement and MFC-DC Oversight Activities

A. QUALITY IMPROVEMENT PROGRAM

MFC-DC has a history of delivering quality care to its enrollees. In order to maintain and continually improve the quality of care it delivers, MFC-DC has created a comprehensive Quality Improvement (QI) program.

MFC-DC 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 Chief Medical Officer and comprised of qualified medical professionals and MFC-DC staff.

A Quality Improvement Plan (QI Plan) is developed annually and reviewed/updated monthly to ensure MFC-DC 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 enrollee outcomes;
- Processes for utilizing data to drive necessary changes to MFC-DC'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, MFC-DC 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 enrollee 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 MFC-DC's quality improvement processes and clinical care. The audit assesses the structure, process and outcome of MFC-DC's internal quality program; and
- The DC Collaborative Perinatal Risk Screening tool (prenatal care providers only).

MFC-DC 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 MFC-DC and each delegated entity.

Quality of Care (QOC)/Peer Review Committee

This committee performs formal peer review of all quality concerns received from any source that indicate an MFC-DC-credentialed provider or practitioner is suspected of violating the standard of care. This Committee functions as an advisory board providing the medical expertise necessary for quality of care case reviews and physician oversight. Its functions include acting as an advisory board on clinical matters to the Compliance Department, performing peer-review, acting as a referral to the Credentialing Committee, and supporting the QI/UM Committee in monitoring physician corrective action plans when necessary.

Provider Role in Quality Management

In order to fully carry out its Quality Improvement functions, MFC-DC 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, MFC-DC 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 enrollees.

2. Provider Performance Measurement. In order to ensure quality care for our enrollees, MFC-DC 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. MFC-DC 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, MFC-DC may perform chart audits. MFC-DC 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 MFC-DC's QOC/Peer Review Committee, which meets quarterly to discuss all referred cases. The QOC/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. MFC-DC 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 enrollee interviews, medical record reviews, and review of staff and provider qualifications.

Provider Performance Data

Providers agree that MFC-DC 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 enrollee cost sharing
- Other quality activities

Additional Information

Additional information regarding the MFC-DC QI efforts can be found on our website. You may also request this information in writing by calling Provider Relations at **855-798-4244**.

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 MFC-DC at **855-798-4244**. MFC-DC 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 Chief Medical Officer , 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. MFC-DC COMPLIANCE PROGRAM

Fraud, Waste and Abuse

MFC-DC 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, enrollee, or even an employee of the MCO. As a MFC-DC 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 an enrollee'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 MFC-DC with monitoring, identifying, and deterring these types of activities. As a result, MFC-DC has created a comprehensive Fraud, Abuse, and Waste Compliance Program ("Compliance Program"), overseen by the Compliance Officer.

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, MFC-DC 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, MFC-DC may retract payments made to providers. In addition, MFC-DC 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:

- The reason for retractions of payments
- The amount to be retracted
- A list of claims that will be retracted
- 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
Appeals Processing
P.O. Box 43790
Baltimore, MD 21236

If additional documentation is available to support the reversal of the denied services, these should be submitted at this time. MFC-DC will send a written acknowledgement to the provider of receipt of the appeal within 5 business days. MFC-DC 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-DC or his/her designee. A written request must be filed within 30 calendar days of MFC-DC's notice of decision of the first level of appeal. MFC-DC 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.

Access to Records

The District, CMS, the HSS Inspector General, the Comptroller General, or their designees have the right at any time to audit, evaluate, and inspect all documents, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the managed care organization.

Exclusion Lists

MFC-DC is prohibited from paying for items or services furnished by a provider or organization that has been excluded from the Medicaid program. MFC-DC 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 MFCs are on this list. For more information regarding how to access the exclusion lists, providers should refer EPLS's website.

False Claims Act

In addition to the Compliance Program described above, it is important that MFC-DC 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, MCOs 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 MFC-DC website or by contacting the MFC-DC provider relations department.

While MFC-DC monitors for possible fraud and abuse activities, MFC-DC asks its providers help to eliminate fraud and abuse. **Providers suspecting fraud and abuse must report this immediately by calling the MFC-DC Compliance Officer or Provider Relations at 855-798-4244**. Providers may remain anonymous and all reports will be kept confidential. In addition, MFC-DC 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.

C. GRIEVANCES AND APPEALS REPORTING

MFC-DC is responsible for gathering and reporting regularly to the District information about enrollee's appeals and grievances and our interventions and resolution to these appeals and grievances. The reports contain data on appeals and grievances in a standardized format and are submitted on a monthly basis.

To accomplish this, MFC-DC is required to operate a Consumer Services Hotline and Internal grievance process.

MedStar Family Choice-DC Enrollee Hotline

MFC-DC maintains an enrollee services unit that operates an Enrollee Services Department which is available Monday through Friday 8:00 a.m. to 5:30 p.m. Calls or faxes received after hours will be addressed the next business day. This unit handles and resolves or properly refers enrollees' inquiries or complaints to the appropriate individuals within MFC-DC. MFC-DC establishes goals for average speed of answer (less than 20 seconds) and call abandonment rate for enrollee services lines for MFC-DC and for the delegated vendors who field enrollee services calls.

MedStar Family Choice-DC Enrollee Grievance/Appeal Policy and Procedures

MFC-DC has written grievance policies and procedures whereby an enrollee who is dissatisfied with the MCO or its network may seek recourse verbally or in writing from the MFC-DC Enrollee Services Department.

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

Any of the following may file a Grievance or Appeal:

1. The Enrollee affected by the determination;
2. If the Enrollee is a minor child, the enrollee's parent, guardian or authorized representative;
3. In the case of a Grievance, an authorized representative, including but not limited to, an Attorney, a MFC-DC staff member, or other non-legal advocate, acting on behalf of the Enrollee; and
4. In the case of an Appeal, an authorized representative, or a Provider acting on behalf of the Enrollee and with the Enrollee's written consent

No punitive action will be taken against the enrollee for making a grievance or appeal against MFC-DC.

Enrollee Complaint/Grievance Procedure

If enrollees 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 Enrollee Services toll-free at **888-404-3549** Monday through Friday, 8:00 am to 5:30 pm. The enrollee service representative will:

1. Take the grievance
2. Answer any questions
3. Tell the enrollee when he/she will have an answer MFC-DC has up to 30 days to provide a response to the grievance. MFC-DC may ask for additional time (up to an additional 14 days) to resolve the grievance if requested by the enrollee, provider or if MFC-DC can show that additional time would be beneficial to the enrollee.
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 enrollee is not satisfied with the resolution of the complaint/grievance he/she may request a fair hearing.

Medical Coverage Appeal Process for Enrollees

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

When the enrollee does not agree with MFC-DC's decision to deny, stop or reduce a service that has been requested by a provider, the enrollee can ask MFC-DC to review our decision again. Enrollees may appeal MFC-DC's decision to cover a service once they receive a denial (adverse determination) letter from MFC-DC. Enrollees or their authorized representative may file an appeal orally or in writing within 60 calendar days from the date of the notice of the Adverse Benefit Determination. The letter provides the details of why the medical services were denied. It also gives instructions on the appeals process and the fair hearing process. MFC-DC can also provide the enrollee with information on how to request a fair hearing.

Medical appeals are either urgent (expedited) or non-urgent (standard). Appeals are considered to be urgent if the enrollee'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 enrollee severe pain.

The appeal, verbal or written, must include the specific reason for reconsidering the denial. The enrollee may file the appeal on their own. MFC-DC has a simple form which enrollees can use to file their appeal. Enrollees can obtain this form by calling **888-404-3549**. MFC-DC will mail or fax the appeal form to the enrollee 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 enrollee, enrollees may have their provider or an authorized representative file the appeal on their behalf. A form is available on our website that can be used to help enrollees grant written permission for providers to appeal on behalf of enrollees. An appeal will not be processed until a signed form has been received from the enrollee stating the provider may appeal on the enrollee's behalf.

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

MedStar Family Choice-DC
Director of Medicaid Contract Oversight
3007 Tilden St, NW
Washington, DC 20008

Verbal requests for appeals can be obtained by calling **888-404-3549**. MFC-DC will send a letter to the enrollee acknowledging receipt of the appeal within two business days. When an appeal is filed, MFC-DC should be notified of any new information that will help MFC-DC make a decision. While the appeal is being reviewed, MFC-DC can still receive any additional information that the provider thinks will help MFC-DC make a decision.

When reviewing the appeal MFC-DC will:

- Review the appeal at the Grievance and Appeal Committee
- 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 an expedited appeal within 72 hours from the date MFC-DC receives the appeal.
- Make a decision about a standard appeal within 30 calendar days from the date MFC-DC receives the appeal.
- MFC-DCmay extend the timeframe up to 14 days if requested by the enrollee, or if MFC-DC can show to the DHCF that an extension would benefit the enrollee
- If MFC-DC denies a request for an expedited appeal, MFC-DC will process the appeal within the standard appeal timeframe and make reasonable efforts to promptly alert the enrollee of the denial orally and follow-up with a written notice within two (2) calendar days.

MFC-DC will notify providers and enrollees of the decision within the following timeframes:

- Expedited Appeals: Oral notification via telephone will be communicated to the Provider affected, within twenty-four (24) hours of the decision, not to exceed 72 hours from the date MFC-DC receives the appeal. In the case of expedited appeals, MFC-DC will also make reasonable efforts to provide oral notice of the decision to the enrollee. Written notification will be sent to all affected parties (provider, enrollee and facility if applicable) within 72 hours from the date MFC-DC receives the appeal.

- Standard Pre-service appeals: Written notification will be sent to the provider and the enrollee within 30 calendar days of the date the MCO receives the appeal.
- Post-service appeals: Written notification will be sent to the provider and the enrollee within 30 calendar days of the date MFC-DC receives the appeal.

Written notice of the appeal resolution will include the results and date of the Appeal resolution, the Enrollee's right to request a District Fair Hearing and how to do so, the Enrollee's right to receive benefits while the Fair Hearing is pending, and how to make the request.

District Fair Hearings

The enrollee or his/her authorized representative may request a Fair Hearing after exhausting the MFC-DC appeal process. The enrollee has 120 calendar days after the date of the final notice of the adverse determination to request a Fair Hearing. MFC-DC will provide each enrollee 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, MFC-DC will submit all documents regarding the Action and the enrollee's dispute to DHCF. The District's decision will be final and cannot be appealed.

Continuation of Benefits During Pending Appeals and District Fair Hearings

While the District Fair Hearing is pending, the enrollee is entitled to have their benefits continued if the following requirements are met:

1. The enrollee files the request for appeal timely.
2. The appeal involves the termination, suspension, or reduction of previously authorized services.
3. The services were ordered by an authorized provider.
4. The period covered by the original authorization has not expired, and
5. The enrollee files for continuation of benefits timely. (Timely means or before the later of the following: Within 10 calendar days of the notice of adverse benefit determination; the intended effective date of the proposed adverse benefit determination).

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, MFC-DC will authorize or provide the disputed services no later than 2 business days after the reversal or notification of reversal from the District and MFC-DC will provide services within 24 hours of the reversal for expedited appeals.

For information pertaining to Provider Grievance and Appeals please see the Claims Section of the Manual.

MedStarFamilyChoice.com

MedStar Family Choice

DISTRICT OF COLUMBIA

Enrollee Services

3007 St., N.W., Pod 3N
Washington, DC 20008
888-404-3549 (toll free)

20-MFCDC-0041

DHCF
Department of Health Care Finance

WE ARE WASHINGTON DC GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.