JAI MEDICAL SYSTEMS MANAGED CARE ORGANIZATION, INC.

HealthChoice Provider Manual

2023

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HealthChoice Provider Manual
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SECTION I.
INTRODUCTION

THE MARYLAND HEALTHCHOICE PROGRAM

MEDICAID and HEALTHCHOICE
HealthChoice is the name of Maryland Medicaid's managed care program. There are approximately 1.2 million Marylanders enrolled in Medicaid and the Maryland Children's Health Program. With few exceptions Medicaid beneficiaries under age 65 must enroll in HealthChoice. Individuals that do not select a Managed Care Organization (MCO) will be auto-assigned to an MCO with available capacity that accepts new enrollees in the county where the beneficiary lives. Individuals may apply for Medicaid, renew their eligibility and select their MCO on-line at www.marylandhealthconnection.gov or by calling 1-855-642-8572 (TYY: 1-855-642-8572). Members are encouraged to select an MCO that their Primary Care Provider (PCP) participates with. If they do not have a PCP they can choose one at the time of enrollment. MCO members who are initially auto-assigned can change MCOs within 90 days of enrollment. Members have the right to change MCOs once every 12 months. The HealthChoice Program's goal is to provide patient-focused, accessible, cost-effective, high quality health care**.** The State assesses the quality of services provided by MCOs through various processes and data reports. To learn more about the State's quality initiatives and oversight of the HealthChoice Program go to: https://mmcp.health.maryland.gov/healthchoice/Pages/Home.aspx

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

EVS Phone Number: 1-866-710-1447
EVS Website: www.emdhealthchoice.org.

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

Introduction to Jai Medical Systems Managed Care Organization, Inc.

Jai Medical Systems Managed Care Organization, Inc. is a Medicaid Managed Care Organization providing Medicaid health insurance benefits for the State of Maryland in the HealthChoice program.

Jai Medical Systems Managed Care Organization, Inc. was founded in 1997 and serves a diverse population of children and adults throughout the State of Maryland.

Since our founding, Jai Medical Systems' mission has been to provide high quality healthcare benefits and services to the people of Maryland. We continue this tradition of quality and excellence by working with our members to help identify their healthcare needs, while remaining an active and positive presence within the communities we serve.

Throughout our history of service, Jai Medical Systems has been consistently ranked by the State of Maryland as one of the highest rated Managed Care Organizations for quality*. Jai Medical Systems' commitment to our members and high quality healthcare is demonstrated by our performance in health insurance quality measures, such as HEDIS®.

Member Rights and Responsibilities

Please see Attachment N.

HIPAA and Member Privacy Rights

Please see Attachment O.

Anti-Gag Provisions

Providers participating with Jai Medical Systems will not be restricted from discussing with or communicating to a member, enrollee, subscriber, public official, or other person information that is necessary or appropriate for the delivery of health care services, including:

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

Participating Providers agree that a determination by Jai Medical Systems that a particular course of medical treatment is not a covered benefit shall not relieve Participating Providers from recommending such care as he/she deems to be appropriate nor shall such benefit determination be considered to be a medical determination. Participating Providers further agree to inform beneficiaries of their right to appeal a coverage determination pursuant to the applicable grievance procedures and according to law. **Providers contracted with multiple MCOS are prohibited from steering recipients to any one specific MCO.**

Assignment and Reassignment of Members

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

- If they move to another county where **Jai Medical Systems** does not offer care;
- If they become homeless and find that there is another MCO closer to where they live or have shelter which would make getting to appointments easier;
- If they or any member of their family have a doctor in a different MCO and the adult member wishes to keep all family members together in the same MCO;
- If a child is placed in foster care and the foster care children or the family members receive care by a doctor in a different MCO than the child being placed, the child being

placed can switch to the foster family's MCO; or

- The member desires to continue to receive care from their primary care provider (PCP) and the MCO terminated the PCP's contract for one of the following reasons:
    - For reasons other than quality of care;
    - The provider and the MCO cannot agree on a contract for certain financial reasons; or
    - Their MCO has been purchased by another MCO.
- Newborns are enrolled in the MCO the mother was enrolled in on the date of delivery and cannot change for 90 days.

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

Jai Medical Systems is required to provide PCPs with their rosters on a monthly basis. Jai Medical Systems will mail out member panel reports on a monthly basis to participating PCPs. PCPs should note that information changes daily and the monthly member panel report should not be used to determine member eligibility. MCO members may change PCPs at any time. Members can call Jai Medical Systems' Member Services Monday-Friday 9am-6pm at 1-888-JAI-1999 to change their PCP.

Credentialing and Contracting with Jai Medical Systems

Prospective providers who wish to join Jai Medical Systems Managed Care Organization, Inc.'s provider network must submit a letter of intent to Jai Medical Systems Managed Care Organization, Inc. stating their interest in joining the provider network. The Provider Relations Department applies initial credentialing and recredentialing standards to ensure that the prospective and current providers are in compliance with Jai Medical Systems Managed Care Organization, Inc.'s Quality Assurance standards. These standards include National Committee for Quality Assurance (NCQA) Standards, Maryland laws and regulations, and federal rules.

1. Jai Medical Systems Managed Care Organization, Inc. shall not discriminate in contracting, reimbursement, or indemnification of any provider based solely on the license or certification of the provider if the provider is acting within the scope of the license or certification.
2. Jai Medical Systems Managed Care Organization, Inc. does not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or on patient type in which the provider specializes.

Provider Reimbursement

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

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

Self-Referral and Emergency Services

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

The State allows members to self-refer to out of network providers for the services listed below. **Jai Medical Systems** will **pay out of plan providers** the State's Medicaid rate for the following services:

- Emergency services provided in a hospital emergency facility and medically necessary post-stabilization services;
- Family planning services excluding sterilizations;
- Maryland school-based health center services. School-based health centers are required to send a medical encounter form to the child's MCO. We will forward this form to the child's PCP who will be responsible for filing the form in the child's medical record. See Attachment A for a sample School Based Health Center Report Form;
- Pregnancy-related services when a member has begun receiving services from an out-of-plan provider prior to enrolling in an MCO;
- Initial medical examination for children in state custody (Identified by Modifier 32 on the claim);
- Annual Diagnostic and Evaluation services for members with HIV/AIDS;
- Renal dialysis provided at a Medicare-certified facility;
- The initial examination of a newborn by an on-call hospital physician when we do not provide for the service prior to the baby's discharge; and
- Services performed at a birthing center;
- Children with special healthcare needs may self-refer to providers outside of **Jai Medical Systems** network under certain conditions. See Section II for additional information.

If a provider contracts with **Jai Medical Systems** for any of the services listed above the provider must follow our billing and preauthorization procedures. Reimbursements will be paid the contracted rate.

Maryland Continuity of Care Provisions

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

- Is new to the HealthChoice Program;
- Switched from another company's health benefit plan; or
- Switched to **Jai Medical Systems** from another MCO.

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

- Dental Services

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

Preauthorization for health care services
If the previous MCO or company preauthorized services we will honor the approval if the member calls **1-888-JAI-1999**. Under Maryland law, insurers must provide a copy of the preauthorization within 10 days of the member's request. There is a time limit for how long we must honor this preauthorization. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date the member's coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health practitioner after the baby is born.

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

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

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

If the member has any questions, they should call **Jai Medical Systems** Member Services at **1-888-JAI-1999** or the State's HealthChoice Help Line at 1-800-284-4510.

Section II.

OUTREACH AND SUPPORT SERVICES, APPOINTMENT SCHEDULING, EPSDT AND SPECIAL POPULATIONS

MCO Outreach and Support Services

Jai Medical Systems' Outreach Department is available to assist network providers with patient outreach efforts. The Outreach Department is intended to supplement each provider's own outreach efforts and should be contacted only after the provider has made every effort to contact the patient. To refer a patient to Jai Medical Systems' Outreach Department, simply call 1-888-JAI-1999 or (410) 433-2200 and ask for the Director of Outreach.

State Non-Emergency Medical Transportation (NEMT) Assistance

If a member needs transportation assistance contact the local health department (LHD) to assist members in accessing non-emergency medical transportation services (NEMT). Jai Medical Systems will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD. **See Attachment Q for NEMT contact information.**

MCO Transportation Assistance

Under certain circumstances Jai Medical Systems may provide limited transportation assistance when members do not qualify for NEMT through the LHD. You may contact the Local Health Department (LHD) to assist members in accessing non-emergency transportation services. Jai Medical Systems will cooperate with and make reasonable efforts to accommodate logistical and scheduling concerns of the LHD.

Jai Medical Systems will provide non-emergency transportation necessary for our members to access a covered service if we choose to provide the service at a location that is outside of the closest county (or Baltimore City) in which the service is available. Please also refer to the Local Transportation Contacts list in **Attachment Q.**

State Support Services

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

Scheduling Initial Appointments

HealthChoice members must be scheduled for an initial appointment within 90 days of enrollment, unless one of the following exceptions apply:

- You determine that no immediate initial appointment is necessary because the member already has an established relationship with you.
- For children under 21, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) periodicity schedule requires a visit in a shorter timeframe. For example, new members up to two years of age must have a well-child visit within 30 days of enrollment unless the child already has an established relationship with a provider and is not due for a well-child visit.
- For pregnant and post-partum women who have not started to receive care, the initial health visit must be scheduled and the women seen within 10 days of a request.
- As part of the MCO enrollment process the State asks the member to complete a Health Services Needs Information (HSNI) form. This information is then transmitted to the

MCO. A member who has an identified need must be seen for their initial health visit within 15 days of **Jai Medical Systems'** receipt of the HSNI.

- During the initial health visit, the PCP is responsible for documenting a complete medical history and performing and documenting results of an age appropriate physical exam.
- In addition, at the initial health visit, initial prenatal visit, or when a member's physical status, behavior, or laboratory findings indicate possible substance use disorder, you must refer the member to the Behavioral Health System at 1-800-888-1965.

Early Periodic Screening Diagnosis and Treatment (EPSDT) Requirements

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

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

- Notify members of their due dates for wellness services and immunizations**.**
- Schedule and provide preventive health services according to the State's EPSDT Periodicity Schedule and Screening Manual.
- Refer infants and children under age 5 and pregnant teens to the Supplemental Nutritional Program for Women Infants and Children (WIC). Provide the WIC Program with member information about hematocrits and nutrition status to assist in determining a member's eligibility for WIC.
- Participate in the Vaccines For Children (VFC) Program. Many of the routine childhood immunizations are furnished under the VFC Program. The VFC Program provides free vaccines for health care providers who participate in the VFC Program. We will pay for new vaccines that are not yet available through the VFC Program.
- Schedule appointments at an appropriate time interval for any member who has an identified need for follow-up treatment as the result of a diagnosed condition.

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

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

- Is identified as being at risk of a developmental delay by the developmental screen required by EPSDT;
- Has a 25% or more delay in any developmental area as measured by appropriate diagnostic instruments and procedures;
- Manifests atypical development or behavior; or

- Has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

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

EPSDT Outreach and Referral to LHD

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

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

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

Within 10 days of the child missing the second consecutive appointment, request assistance in locating and contacting the child's parent, guardian or caretaker by calling **Jai Medical Systems** at **1-888-JAI-1999.** You may concurrently make a written referral to the LHD ACCU by completing the Local Health Services Request form. **See Attachment B.** Continue to work collaboratively with **Jai Medical Systems** and the ACCU until the child is in care and up to date with the EPSDT periodicity schedule or receives appropriate follow-up care.

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

Special Populations

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

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

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

- Demonstrate their credentials and experience to us in treating special populations.
- Collaborate with our case management staff on issues pertaining to the care of a special

needs member.
- Document the plan of care and care modalities and update the plan annually.

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

- Upon the request of the member or the PCP, a case manager trained as a nurse or a social worker will be assigned to the member. The case manager will work with the member and the PCP to plan the treatment and services needed. The case manager will not only help plan the care, but will help keep track of the health care services the member receives during the year and serve as the coordinator of care with the PCP across a continuum of inpatient and outpatient care.
- The PCP and our case managers, when required, coordinate referrals for needed specialty care. This includes specialists for disposable medical supplies (DMS), durable medical equipment (DME) and assistive technology devices based on medical necessity. **PCPs should follow the referral protocols established by us for sending HealthChoice members to specialty care networks.**
- We have a Special Needs Coordinator on staff to focus on the concerns and issues of special needs populations. The Special Needs Coordinator helps members find information about their condition or suggests places in their area where they may receive community services and/or referrals. To contact the Special Needs Coordinator call **1-888-JAI-1999.**
- Providers are required to treat individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 (P.L. 101-336 42 U.S.C. 12101 et. seq. and regulations promulgated under it).

Special Needs Population-Outreach and Referral to the LHD

A member of a special needs population who fails to appear for appointments or who has been non-compliant with a regimen of care must be referred to **Jai Medical Systems**. If a member continues to miss appointments, call **Jai Medical Systems** at **1-888-JAI-1999**. We will attempt to contact the member by mail, telephone and/or face-to-face visit. If we are unsuccessful in these outreach attempts, we will notify the LHD ACCU. You may also make a written referral to the ACCU by completing the Local Health Services Request Form. **See Attachment B** or https://mmcp.health.maryland.gov/pages/Local-Health-Services-Request-Form.aspx. The local ACCU staff will work collaboratively with **Jai Medical Systems** to contact the member and encourage them to keep appointments and provide guidance on how to effectively use their Medicaid/HealthChoice benefits.

Services for Pregnant and Postpartum Women

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

Jai Medical Systems and our providers are responsible for providing pregnancy-related services, which include:

- Comprehensive prenatal, perinatal, and postpartum care (including high-risk specialty care);
- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment form MDH 4850. (For updated form visit: https://health.maryland.gov/mmcp/Documents/Maryland%20Prenatal%20Risk%20Assessment%20-%20Revised%2010.4.22.pdf)
- An individualized plan of care based upon the risk assessment and which is modified during the course of care as needed;
- Appropriate levels of inpatient care, including emergency transfer of pregnant women and newborns to tertiary care centers;
- Case management services;
- Prenatal and postpartum counseling and education including basic nutrition education;
- Nutrition counseling by a licensed nutritionist or dietician for nutritionally high-risk pregnant women.
- Doula support for prenatal visits, attendance at labor and delivery, and postpartum visits;
- Prenatal, postpartum, and infant home visits from pregnancy and childbirth up to two or three years of the child's age.

The State provides these additional services for pregnant women:

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

Encourage all pregnant women to call the State's Help Line for Pregnant Woman at 1-800-456-8900. This is especially important for women who are newly eligible or not yet enrolled in Medicaid. If the woman is already enrolled in HealthChoice call us and also instruct her to call our OB Case Management Department at 1-888-JAI-1999.

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

The prenatal care providers must follow, at a minimum, the applicable American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines. For each scheduled appointment, you must provide written and telephonic, if possible, notice to member of the prenatal appointment dates and times. The prenatal care provider, PCP and **Jai Medical Systems** are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcome. Examples of appropriate referrals include the Women Infants and Children special supplemental nutritional program (WIC). Prenatal care providers are also required to:

- Provide the initial health visit within 10 days of the request.
- Complete the Maryland Prenatal Risk Assessment form-MDH 4850 (visit

https://health.maryland.gov/mmcp/Documents/Maryland%20Prenatal%20Risk%20Assessment%20-%20Revised%2010.4.22.pdf for updated form) during the initial visit and submit it to the Local Health Department within 10 days of the initial visit. **Jai Medical Systems** will pay for the initial prenatal risk assessment- use CPT code H1000.

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

Childbirth Related Provisions

Special rules for length of hospital stay following childbirth:
A member's length of hospital stay after childbirth is determined in accordance with the ACOG and AAP Guidelines for perinatal care unless the 48 hour (uncomplicated vaginal delivery) / 96 hour (uncomplicated cesarean section) length of stay guaranteed by State law is longer than that required under the Guidelines.

If a member must remain in the hospital after childbirth for medical reasons, and she requests that her newborn remain in the hospital while she is hospitalized, additional hospitalization of up to 4 days is covered for the newborn and must be provided.

If a member elects to be discharged earlier than the conclusion of the length of stay guaranteed by State law, a home visit must be provided. When a member opts for early discharge from the hospital following childbirth, (before 48 hours for vaginal delivery or before 96 hours for C-section) one home nursing visit within 24 hours after discharge and an additional home visit, if prescribed by the attending provider, are covered.

Postnatal home visits must be performed by a registered nurse, in accordance with generally

accepted standards of nursing practice for home care of a mother and newborn, and must include:

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

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

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

We are required to schedule the newborn for a follow-up visit within 2 weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit. Breast pumps are covered under certain situations for breastfeeding mothers. Call us at **1-888-JAI-1999.**

Children with Special Health Care Needs

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

New Member: A child who, at the time of initial enrollment, was receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing out-of-network provider submits the plan of care to us for review and approval within 30 days of the child's effective date of enrollment into **Jai Medical Systems** and we approve the services as medically necessary.

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

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

For children with special health care needs **Jai Medical Systems** will:

- Provide the full range of medical services for children, including services intended to improve or preserve the continuing health and quality of life, regardless of the ability of services to affect a permanent cure.
- Provide case management services to children with special health care needs as appropriate. For complex cases involving multiple medical interventions, social services,

or both, a multi-disciplinary team must be used to review and develop the plan of care for children with special health care needs.

- Refer special needs children to specialists as needed. This includes specialty referrals for children who have been found to be functioning one third or more below chronological age in any developmental area as identified by the developmental screen required by the EPSDT periodicity schedule.
- Allow children with special health care needs to access out-of-network specialty providers under certain circumstances. We log any complaints made to the State or to **Jai Medical Systems** about a child who is denied a service by us. We will inform the State about all denials of service to children. All denial letters sent to children or their representative will state that members can appeal by calling the State's HealthChoice Help Line at (800) 284-4510
- Work closely with the schools that provide education and family services programs to children with special needs.

Children in State-Supervised Care

We will ensure coordination of care for children in State-supervised care. If a child in State-supervised care moves out of the area and must transfer to another MCO, the State and **Jai Medical Systems** will work together to find another MCO as quickly as possible.

Individuals with HIV/AIDS

We are required to provide the following services for persons with HIV/AIDS:

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

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

Individuals with Physical or Developmental Disabilities

Providers who treat individuals with physical or developmental disabilities must be trained on the special communications requirements of individuals with physical disabilities. We are

responsible for accommodating hearing impaired members who require and request a qualified interpreter. We can delegate the financial risk and responsibility to our providers, but we are ultimately responsible for ensuring that our members have access to these services.

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

Homeless Individuals

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

Rare and Expensive Case Management Program

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

SECTION III.

HEALTHCHOICE BENEFITS AND SERVICES

MCO BENEFITS AND SERVICES OVERVIEW

Jai Medical Systems must provide comprehensive benefits equivalent to the benefits that are available to Maryland Medicaid participants through the Medicaid fee-for-service system. Only benefits and services that are medically necessary are covered.

Audiology Services

Audiology services will be covered by **Jai Medical Systems** for both adults and children. For individuals under age 21, bilateral hearing amplification devices are covered by the MCO. For adults 21 and older, unilateral hearing amplification devices are covered by the MCO. Bilateral hearing amplification devices are only covered for adults 21 and older when the individual has a documented history of using bilateral hearing aids before age 21.

Blood and Blood Products

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

Case Management Services

We cover case management services for members who need such services including, but not limited to**,** members of State designated special needs populations as described in Section II. If warranted, a case manager will be assigned to a member when the results of the initial health screen are received by the MCO or when requested by the State. A case manager may conduct home visits as necessary as part of **Jai Medical Systems** case management program.

Case Management, Complex Case Management, and Disease Management programs are available for Jai Medical Systems' members, who have serious medical conditions or have complex and/or special needs. Our Case Managers can also assist with care coordination.

Currently, there are Disease Management Programs for Hypertension and Asthma. These Disease Management programs provide our members with additional information and support while helping them control their high blood pressure and asthma.

Case Management and Complex Case Management services are also available to our members. Case Management and Complex Case Management services provide support and guidance to those members that need or would like extra assistance with their health care.

If you feel that one of our members may benefit from Case Management, Complex Case Management or Disease Management services, please contact our Utilization Management team at 1-888-JAI-1999.

Clinical Trial Items and Services

We cover certain routine costs that would otherwise be a cost to the member.

Dental Services

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

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

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

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

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

Please see Attachment R.

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

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

Disease Management
We offer disease management for members with the following chronic conditions:

- Hypertension (High Blood Pressure)
- Asthma

Durable Medical Services and Durable Medical Equipment
We cover medically necessary DMS/DME services. We must provide authorization for DME and/or DMS within a timely manner so as not to adversely affect the member's health and within 2 business days of receipt of necessary clinical information but not later than 14 calendar days

from the date of the initial request. We must pay for any durable medical equipment authorized for members even if delivery of the item occurs within 90 days after the member's disenrollment from **Jai Medical Systems**, as long as the member remains Medicaid eligible during the 90-day time period.

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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
We must cover the EPSDT services listed below for members under 21 years of age:

Well-child services provided in accordance with the EPSDT/Healthy Kids periodicity schedule by an EPSDT-certified provider, including:

- Periodic comprehensive physical examinations;
- Comprehensive health and developmental history, including an evaluation of both physical and
- mental health development;
- Immunizations;
- Laboratory tests including blood level assessments;
- Vision, hearing, and oral health screening; and
- Health education

The State must also provide or assure the MCO provides Expanded EPSDT services and partial or inter-periodic well-child services necessary to prevent, treat, or ameliorate physical, mental, or developmental problems or conditions. Services must be sufficient in amount, duration, and scope to treat the identified condition, and all must be covered subject to limitations only based on medical necessity. These include such services as:

- Chiropractic services;
- Nutrition counseling;
- Private duty nursing services;
- Durable medical equipment including assistive devices; and
- Behavioral Health services

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

Family Planning Services
We will cover comprehensive family planning services such as:

- Office visits for family planning services;
- Laboratory tests including pap smears;

- All FDA approved contraceptive devices; methods and supplies;
- Immediate Postpartum Insertion of IUDs
- Oral Contraceptives (must allow 12-month supply to be dispensed for refills);
- Emergency contraceptives and condoms without a prescription;
- Voluntary sterilization procedures (Sterilization procedures are not self-referred; member must be 21 years of age and must use in-network provider or have authorization for out of network care.)

Gender Transition Services
We cover medically necessary gender reassignment surgery and other somatic care for members with gender identity disorder.

Habilitation Services
We cover habilitation services when medically necessary for certain adults who are eligible for Medicaid under the ACA. These services include physical therapy, occupational therapy and speech therapy. If you have questions about which adults are eligible call **1-888-JAI-1999**.

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

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

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

Inpatient Hospital Services
We cover inpatient hospital services. **Jai Medical Systems** is not responsible for payment of any remaining days of a hospital admission that began prior to the individual's enrollment in our MCO. We are however, responsible for reimbursement of professional services rendered during the remaining days of the admission if the member remains Medicaid eligible.

Nursing Facility Services
For members that were enrolled in **Jai Medical Systems** prior to admission to a nursing facility,

chronic hospital or chronic rehabilitation hospital and who meet the State's level of care (LOC) criteria, Jai Medical Systems is responsible for up to 90 days of the stay subject to specific rules.

Outpatient Hospital Services and Observation
We cover medically necessary outpatient hospital services. As required by the State we limit observation stays to 24 hours.

Outpatient Rehabilitative Services
We cover outpatient rehabilitative services including but not limited to medically necessary physical therapy for adult members. For members under 21 rehabilitative services are covered by **Jai Medical Systems** when the service is part of a home health visit or inpatient hospital stay.

Oxygen and Related Respiratory Equipment
We cover oxygen and related respiratory equipment.

Pharmacy Services and Copays
We are responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program. We cover medical supplies or equipment used in the administration or monitoring of medication prescribed or ordered for a member by a qualifying provider. Most behavioral health drugs are on the State's formulary and are the responsibility of the State

There are no pharmacy co-pays for children, pregnant women, individuals in nursing facilities or hospice, or birth control. For drugs covered by the State, such as behavioral health drugs, pharmacy copays are $1 for generic drugs, preferred brand name drugs, and HIV/AIDS, and $3 for brand name drugs.

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

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

Pregnancy-Related Care
Jai Medical Systems and our providers are responsible for providing pregnancy-related services, which include:

- Prenatal risk assessment and completion of the Maryland Prenatal Risk Assessment form;
- 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;
- Basic nutritional education;
- Special substance abuse treatment including access to treatment within 24 hours of request and intensive outpatient programs that allow for children to accompany their mother;
- 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; and
- Referral to the ACCU.

The PCP, OB/GYN, and Jai Medical Systems are responsible for making appropriate referrals of pregnant members to publicly provided services that may improve pregnancy outcome. Examples of appropriate referrals include the Women, Infants, and Children special supplemental nutritional program (WIC) and the local health departments' ACCU. In connection with such referrals, necessary medical information will be supplied to the program for the purpose of making eligibility determinations.

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

You 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 Maryland Prenatal Risk Assessment form-MDH 4850 (Attachment R) for each pregnant member and submit it to the Local Health Department in the jurisdiction in which the member lives within 10 days of the initial visit.
- For pregnant members under the age of 21, refer them to their PCP to have their EPSDT screening services provided.
- Reschedule appointments within 10 days for members who miss prenatal appointments.
- Refer to the WIC Program.

- Refer pregnant and postpartum members who are in need of treatment for a substance use disorder for appropriate substance abuse assessments and treatment services through the Behavioral Health System.

- Offer HIV counseling and testing and provide information on HIV infection and its effects on the unborn child.

- Instruct pregnant member to notify the MCO of her pregnancy and her expected date of delivery after her initial prenatal visit.

- Instruct the pregnant member to contact the MCO for assistance in choosing a PCP for the newborn prior to her eighth month of pregnancy.

- Document the pregnant member's choice of pediatric provider in the medical record.

- Advise the pregnant member that she should be prepared to name the newborn at birth. This is required for the hospital to complete the "Hospital Report of Newborns," DHMH 1184 and get the newborn enrolled in HealthChoice. **Please see attachment E.**

Primary Behavioral Health Services

We cover primary behavioral health services, including assessment, clinical evaluation and referral for additional services. The PCP may elect to treat the member, if the treatment, including visits for Buprenorphine treatment, falls within the scope of the PCP's practice, training, and expertise. Referrals for behavioral health services can be made by calling the State's ASO at 1-800-888-1965, Monday - Friday: 8:00 AM to 6:00 PM.

Specialty Care Services

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

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

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

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

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

Telemedicine and Remote Patient Monitoring
We must offer telemedicine and remote patient monitoring to the extent they are covered by the Medicaid FFS Program.

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

Vision Care Services
We cover medically necessary vision care services. We are required to cover one eye examination every two years for members age 21 or older; and for members under age 21, at least one eye examination every year in addition to EPSDT screening. For members under age 21 we are required to cover one pair of eyeglasses per year unless lost, stolen, broken, or no longer vision appropriate; contact lenses, must be covered if eyeglasses are not medically appropriate for the condition. **Jai Medical Systems** covers additional vision services for adults.

Effective July 1, 2013, Versant Health, formerly Superior Vision became Jai Medical Systems' Optometric Vision Benefits Manager and Administrator. Please contact Versant Health at 1-800-428-8789 for any vision care questions. Ophthalmology services are still covered through Jai Medical Systems' specialty care network and require a referral.

OPTIONAL SERVICES COVERED BY JAI MEDICAL SYSTEMS
In addition to those services previously noted **Jai Medical Systems** currently provides the following optional services to our members. These services are not taken into account when setting our capitation rate. MCO optional services may change each Calendar Year. We may not discontinue or reduce these services without providing advance notification to State.

Vision Services for Adults 21 Years and Older:
- One exam every year.
- One pair of eyeglasses every 2 years.

MEDICAID BENEFITS COVERED BY THE STATE - not covered by Jai Medical Systems

- **The State covers dental** services for children under age 21, HealthChoice adults, former foster care youth up to age 26, and pregnant women. The Maryland Healthy Smiles Dental Program is responsible for routine preventative services, restorative service and orthodontia. Orthodontia must meet certain criteria and requires preauthorization by SKYGEN USA the State's ASO. SKYGEN USA assigns members to a dentist and issues a dental Healthy Smiles ID card. However, the member may go to any Healthy Smiles participating dentist. If you have questions about dental benefits, call 1-855-934-9812.
- Outpatient rehabilitative services for children under age 21;
- Specialty mental health and substance use disorders covered by the Specialty Behavioral Health System;
- Intermediate Care Facilities for Individuals with Intellectual Disabilities or Persons with developmental disabilities;
- Personal care services;
- Medical day care services, for adults and children;

- Abortions (covered under limited circumstances – no Federal funds are used -claims are paid through the Maryland Medical Care Program). If a woman was determined eligible for Medicaid based on her pregnancy she is not eligible for abortion services;
- Emergency transportation (billed by local EMS);
- Non-emergency transportation services provided through grants to local governments;
- Services provided to members participating in the State's Health Home Program; and
- Certain high-cost low-volume drugs.

BENEFIT LIMITATIONS
Jai Medical Systems does not cover these services except where noted and the State does not cover these services.

- Services performed before the effective date of the member's enrollment in the MCO are not covered by the MCO but may be covered by Medicaid fee-for-service if the member was enrolled in Medicaid;
- Services that are not medically necessary;
- Services not performed or prescribed by or under the direction of a health care practitioner (i.e., by a person who is licensed, certified, or otherwise legally authorized to provide health care services in Maryland or a contiguous state);
- Services that are beyond the scope of practice of the health care practitioner performing the service;
- Experimental or investigational services, including organ transplants determined by Medicare to be experimental, except when a member is participating in an authorized clinical trial;
- Cosmetic surgery to improve appearance or related services, but not including surgery and related services to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental abnormalities;
- While enrolled in an MCO, services, except for emergency services, are not covered when the member is outside the State of Maryland unless the provider is part of **Jai Medical Systems** network. Services may be covered when provided by an MCO network provider who has obtained the proper referral or pre-authorization if required. If a Medicaid beneficiary is not in an MCO on the date of service, Medicaid fee-for service may cover the service if it is a covered benefit and if the out of state provider is enrolled in Maryland Medicaid;.
- Services provided outside the United States;
- Immunizations for travel outside the U.S.;
- Piped-in oxygen or oxygen prescribed for standby purposes or on an as-needed basis;
- Private hospital room is not covered unless medically necessary or no other room is available;
- Autopsies;
- Private duty nursing services for adults 21 years old and older;
- Orthodontia is not covered by the MCO but may be covered by Healthy Smiles when the member is under 21 and scores at least 15 points on the Handicapping Labio-lingual Deviations Index No. 4 and the condition causes dysfunction;
- Ovulation stimulants, in vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar;
- Reversal of voluntary sterilization procedures;

- Reversal of gender reassignment surgeries;
- Medications for the treatment of sexual dysfunction;
- MCOs are not permitted to cover abortions. We are required to assist women in locating these services and we are responsible for related services (sonograms, lab work, but the abortion procedure, when conditions are met, must be billed to Medicaid fee-for service;
- Non-legend chewable tablets of any ferrous salt when combined with vitamin C, multivitamins, multivitamins and minerals, or other minerals in the formulation when the member is under 12 years old and non-legend drugs other than insulin and enteric-coated aspirin for arthritis;
- Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;
- Diet and exercise programs for weight loss except when medically necessary;
- Lifestyle improvements (physical fitness programs and nutrition counseling, unless specified); and
- MCOs do not cover emergency transportation services and are not required to cover non-emergency transportation services (NEMT). **Jai Medical Systems** will assist members to access non-emergency transportation through the local health department. We will provide some transportation if necessary to fill any gaps that may temporarily occur in our network. Please see **Attachment Q**.

Section IV

PRIOR AUTHORIZATION
AND
MEMBER COMPLAINT, GRIEVANCE
AND APPEAL PROCEDURES

Services requiring prior authorization

All inpatient and outpatient **admissions and procedures** must be pre-certified by the Jai Medical Systems Utilization Management (UM) Department. The UM Department may be reached on its direct line 410- 433-5600 or by calling Jai Medical Systems' main number 1-888-JAI-1999. A comprehensive list of services and procedures requiring pre-certification and/or prior authorization can be found in **Attachment G**.

For more specific information regarding procedures which require prior authorization, providers should refer to their contract with Jai Medical Systems. If a provider is unsure whether or not precertification is necessary, he/she should call the Utilization Management Department at the above number prior to rendering services. Payment for services provided without proper authorization or certification may be denied.

Services not Requiring Preauthorization

Many services do not require prior authorization. These services include primary care, urgent care, and emergency services.

Prior authorizations procedures

Please see **Attachment G** for details regarding Jai Medical Systems' Prior Authorization Process and Procedures.

Inpatient Admissions and Concurrent Review

All care provided to Jai Medical Systems members is subject to medical necessity requirements. Jai Medical Systems conducts utilization review for a variety of care, including inpatient admissions and certain outpatient procedures. For more information about Jai Medical Systems Utilization Review program, please contact our Utilization Review Department at 410-433-5600.

Period of preauthorization

Prior authorization numbers are valid for the date of service authorized or for a period not to exceed **90** days after the date of service authorized. The member must be eligible for Medicaid and enrolled in Jai Medical Systems on each date of service. For information about how to verify member eligibility please see below:

Member Eligibility:

In order to verify that a patient is enrolled with Jai Medical Systems, please ask the patient to present his/her member identification card. Further, each provider should call the State of Maryland's Eligibility Verification System (EVS) to verify the patient's enrollment status on the date of service. The number to verify a member's eligibility through EVS is 1-866-710-1447. Providers may also access EVS on the internet at https://encrypt.emdhealthchoice.org/emedicaid/ Instructions on the appropriate use of the EVS system are available from the State Medicaid Program.

Prior authorization and coordination of benefits

Jai Medical Systems may not refuse to pre-authorize a service because the member has other insurance. Even if the service is covered by the primary payer, the provider must follow our prior authorization rules. Preauthorization is not a guarantee of payment. Except for prenatal

care and Healthy Kids/EPSDT screening services, you are required to bill other insurers first. For these services, we will pay the provider and then seek payment from the other insurer.

Medical Necessity Criteria

A "medically necessary" service or benefit must be:

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

Clinical Guidelines

Please see Attachment H.

Timeliness of decisions and notifications to providers and members

Jai Medical Systems makes prior authorization decisions and notifies providers and applicable members in a timely manner. Unless otherwise required by the Maryland Department of Health. **Jai Medical Systems** adheres to the following decision/notification time standards:

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

Jai Medical Systems will send notice to deny authorizations to providers and members:

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

Out-of-Network Providers

When approving or denying a service from an out-of-network provider, Jai Medical Systems will assign a prior authorization number, which refers to and documents the approval. Jai Medical Systems sends written documentation of the approval or denial to the out-of-network provider within the time frames appropriate to the type of request. Refer to Section I for list of self-referred services which are services we must allow members to access out-of- network. Occasionally, a member may be referred to an out-of-network provider because of special needs and the qualifications of the out-of-network provider. Jai Medical Systems makes such decisions on a case-by-case basis.

Overview of Member Complaint, Grievance and Appeal Processes

Our MCO member services line, **1-888-JAI-1999, operates 9:00 AM-6:00 PM.** Member services resolves or properly refers members' inquiries or complaints to the State or other agencies. **Jai Medical Systems** informs members and providers of the grievance system

processes for complaints, grievances, appeals, and Maryland State Fair Hearings. This information is contained in the Member Handbook and is available on the **Jai Medical Systems** website at www.jaimedicalsystems.com**.**

Members or their authorized representatives can file an appeal or a grievance with **Jai Medical Systems** orally or in writing. An authorized representative is someone who assists with the appeal on the member's behalf, including but not limited to a family member, friend, guardian, provider, or an attorney. Representatives must be designated in writing. Providers will not be penalized for advising or advocating on behalf of an enrollee.

Members and their representatives may also request any of the following information from Jai Medical Systems, free of charge, to help with their appeal by calling 1-888-JAI-1999:

- Medical records;
- Any benefit provision, guideline, protocol, or criterion **Jai Medical Systems** used to make its decision;
- Oral interpretation and written translation assistance; and
- Assistance with filling out Jai Medical Systems' appeal forms.

Jai Medical Systems will take no punitive action for:

- Members requesting appeals or grievances
- Providers requesting expedited resolution of appeals or grievances
- Providers supporting a member's appeal or grievance; or
- Members or providers making complaints against **Jai Medical Systems** or the Department

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

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

MCO Member Grievance Procedures

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

Examples of reasons to file an administrative grievance include:

- The member's provider's office was dirty, understaffed, or difficult to access.
- The provider was rude or unprofessional.
- The member cannot find a conveniently located provider for his/her health care needs.
- The member is dissatisfied with the help he/she received from the provider's staff or **Jai**

Medical Systems.

Examples of reasons to file a medical grievance include:

- The member is having issues with filling his/her prescriptions or contacting the provider.
- The member does not feel he/she is receiving the right care for his/her condition.
- **Jai Medical Systems** is taking too long to resolve the member's appeal or grievance about a medical issue.
- **Jai Medical Systems** denies the member's request to expedite his/her appeal about a medical issue.

Grievances may be filed at any time with **Jai Medical Systems** orally or in writing by the member or their authorized representative, including providers. **Jai Medical Systems** responds to grievances within the following timeframes:

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

If we are unable to resolve an urgent or administrative grievance within the specified timeframe, we may extend the timeframe of the grievance by up to fourteen (14) calendar days if the member requests the extension or if we demonstrate to the satisfaction of the Maryland Department of Health (MDH), upon its request, that there is need for additional information and how the delay is in the member's interest. In these cases, we will attempt to reach you and the member by phone to provide information describing the reason for the delay and will follow with a letter within two (2) calendar days detailing the reasons for our decision to extend.

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

MCO Member Appeal Procedures

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

- **Jai Medical Systems** denies covering a service ordered or prescribed by the member's provider. The reasons a service might be denied include:
    - The treatment is not needed for the member's condition, or would not help you in diagnosing the member's condition.
    - Another more effective service could be provided instead.
    - The service could be offered in a more appropriate setting, such as a provider's office instead of the hospital.
- **Jai Medical Systems** limits, reduces, suspends, or stops a service that a member is already receiving. For example:
    - The member has been getting physical therapy for a hip injury and he/she has reached the frequency of physical therapy visits allowed.

    - The member has been prescribed a medication, it runs out, and he/she does not receive any more refills for the medication.
- **Jai Medical Systems** denies all or part of payment for a service a member has received, and the denial was not related to the claim being "clean."
- **Jai Medical Systems** fails to provide services in a timely manner, as defined by the Department (for example, it takes too long to authorize a service a member or his/her provider requested).
- **Jai Medical Systems** denies a member's request to speed up (or expedite) the resolution about a medical issue.

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

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

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

When the member files an appeal, or at any time during our review, the member and/or provider should provide us with any new information that will help us make our decision. The member or representative may ask for up to 14 additional days to gather information to resolve the appeal. If the member or representative needs more time to gather information to help **Jai Medical Systems** make a decision, they may call **Jai Medical Systems** at 1-888-JAI-1999 and ask for an extension.

Jai Medical Systems may also request up to 14 additional days to resolve the appeal if we need to get additional information from other sources. If the MCO requests an extension, the MCO will send the member a letter and call the member and his/her provider.

When reviewing the member's appeal we will:

- Use doctors with appropriate clinical expertise in treating the member's condition or disease;
- Not use the same MCO staff to review the appeal who denied the original request for service; and

- Make a decision within 30 days, if the member's ability to attain, maintain, or regain maximum function is not at risk

On occasion, certain issues may require a quick decision. These issues, known as expedited appeals, occur in situations where a member's life, health, or ability to attain, maintain, or regain maximum function may be at risk, or in the opinion of the treating provider, the member's condition cannot be adequately managed without urgent care or services. **Jai Medical Systems** resolves expedited appeals effectively and efficiently as the member's health requires. Written confirmation or the member's written consent is not required to have the provider act on the member's behalf for an expedited appeal. If the appeal needs to be reviewed quickly due to the seriousness of the member's condition, and **Jai Medical Systems** agrees, the member will receive a decision about their appeal as expeditiously as the member health condition requires or no later than 72 hours from the request. If an appeal does not meet expedited criteria, it will automatically be transferred to a standard timeframe. **Jai Medical Systems** will make a reasonable effort to provide verbal notification and will send written notification within two (2) calendar days.

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

For an expedited appeal timeframe, **Jai Medical Systems** will communicate the decision verbally at the time of the decision and in writing, including an explanation for the decision, within 24 hours of the decision.

If we decide that they should not receive the denied service, that letter will tell them how to ask for a State Fair Hearing.

Request to Continue Benefits During the Appeal

If the member's appeal is about ending, stopping, or reducing a service that was authorized, they may be able to continue to receive the service while we review their appeal. Providers may not request to continue benefits on the member's behalf. The member should contact us within 10 days of receiving the denial notice at **1-888-JAI-1999** if they would like to continue receiving services while their appeal is reviewed. The service or benefit will continue until either the member withdraws the appeal or the appeal or fair hearing decision is adverse to the member. If the member does not win their appeal, they may have to pay for the services that they received while the appeal was being reviewed.

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

State Fair Hearing Rights

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

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

State HealthChoice Help Lines

If a member has questions about the HealthChoice Program or the actions of **Jai Medical Systems** direct them to call the State's HealthChoice Help Line at 1-800-284-4510. Providers can contact the HealthChoice Provider Line at 1-800-766-8692.

Section V.

PHARMACY MANAGEMENT

Pharmacy Benefit Management

Jai Medical Systems is responsible for most pharmacy services and will expand our drug formulary to include new products approved by the Food and Drug Administration in addition to maintaining drug formularies that are at least equivalent to the standard benefits of the Maryland Medical Assistance Program, prescription medications and certain over-the counter medicines.

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

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

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

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

- Medical supplies for compounding prescriptions for home intravenous therapy.

Limitations: The following are not covered by the State or the MCO:

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

Jai Medical Systems contracts with ProCare Rx to provide the following services: pharmacy network contracting and network Point-of-Sale (POS) claim processing.

Mail Order Prescriptions

Except for specialty drugs, members are not required to use mail order pharmacy providers. If a specialty drug is available in a community pharmacy and a member requests to obtain the prescription through the community provider, we will honor the request.

Specialty Pharmacy Services

Jai Medical Systems currently does not exclusively contract with any Specialty Pharmacy.

Jai Medical Systems is responsible for formulary development, drug utilization review, and prior authorization. **Jai Medical Systems'** drug utilization review program is subject to review and approval by MDH and is coordinated with the drug utilization review program of the Behavioral Health Service delivery system.

Prescription and Drug formulary

The current Jai Medical Systems Formulary is available online through Formulary Navigator. It is available at, https://client.formularynavigator.com/Search.aspx?siteCode=9386334079, You should check the formulary before writing a prescription for either prescription or over-the-counter drugs. Jai Medical Systems' members must have their prescriptions filled at a network pharmacy.

Most Behavioral Health medications are paid by Medicaid not the MCO. The State's Medicaid formulary can be found at:
https://client.formularynavigator.com/Search.aspx?siteCode=9381489506

Prescription Copays

There are no copays for children under 21, pregnant women, individuals in a nursing facility or hospice, or family planning.

HealthChoice members may not be charged any co-payments, premiums or cost sharing of any kind, except for the following:

    - Up to a $3.00 co-payment for brand-name drugs;
    - Up to a $1.00 co-payment for generic drugs; and
    - Any other charge up to the fee-for-service limit as approved by the Department.

- Jai Medical Systems will not impose pharmacy co-payments on the following:
    - Family planning drugs and devices;
    - Individuals under 21 years old;
    - Pregnant women; and
    - Institutionalized individuals who are inpatient in long-term care facilities or other institutions requiring spending all but a minimal amount of income for medical costs.

- Limitations on covered services do not apply to children under age 21 receiving medically necessary treatment under the EPSDT program.

- The pharmacy cannot withhold services even if the member cannot pay the co-payment. The member's inability to pay the co-payment does not excuse the debt and they can be billed for the co-payment at a later time.

Over-the-Counter Products

The only over-the-counter (OTC) medications that are covered by Jai Medical Systems are listed within the program formulary. All OTC medications, with the exception of OTC emergency contraception, can be reimbursed only if it is written on a valid prescription form by a licensed prescriber. OTC emergency contraception may be obtained without a written prescription. Our formulary is available online at www.jaimedicalsystems.com/pharmacy. Please see page 6 of the formulary for OTC limitations.

Injectables and Non-Formulary Medications Requiring Prior-Authorization

Jai Medical Systems' formulary is comprehensive and tries to provide appropriate and cost effective drug therapy to all participants in our health plan. If a patient requires medication that is not covered by the formulary, a request can be made for payment for the non-covered item. It is anticipated that such exceptions will be rare, and that formulary medications will be appropriate to treat the vast majority of medical conditions. Requests for non-formulary medications should be made in writing (on the Prior Authorization form, if possible) and mailed or faxed to:

ProCare Rx
Prior Authorization Desk
1267 Professional Parkway
Gainesville, Georgia 30507
(800) 555-8513
(800) 583-6010 (fax)

Prior Authorization Process

To initiate the Prior Authorization process, the prescribing physician may phone or fax the PBM at :
ProCare Rx
Prior Authorization Desk
1267 Professional Parkway
Gainesville, Georgia 30507
(800) 555-8513
(800) 583-6010 (fax)

Please have patient information, including member ID number, complete diagnosis, medication history, and current medications readily available. Special request forms are required for Hepatitis C treatments and for opioids. All forms can be found online at www.jaimedicalsystems.com/providers/pharmacy/.

A completed signed prior authorization form is needed in order for a request to be approved, but providers may call the ProCare Rx Prior Authorization department for prior authorization request forms and for help with the prior authorization request process. These phone lines are dedicated to physicians making requests for prior authorization medication and non-formulary items. Members cannot be assisted if they call the prior authorization toll-free number, but they may call the ProCare Rx Customer Service Department at 800-213-5640 for help getting a prior authorization form faxed to their provider. For all requests for drugs requiring prior authorization, a decision will be provided within 24 hours of receiving the request. That decision will be to either, approve, deny, or request more information. The requesting provider will receive a telecommunication response informing them of this decision. If the requested information is not received, this process could take up to 14 calendar days. If the request is approved, information in the on-line pharmacy claims processing system will be changed to allow the specific patient to receive the requested drug. A prior authorization number will be issued to the prescribing physician and may be clearly written on the top of the prescription to inform the dispensing pharmacist of the approval. This number is for identification purposes only and does not need to be submitted for adjudication to occur. If the request is denied, information about the denial will be provided to the prescribing physician along with the patient and the patient's PCP.

In addition, most injectables (except Depo-Provera, enoxaparin sodium, Makena, insulin, Glucagon Kit, and formulary epinephrine products) require prior approval. Questions about injectable drugs administered by home health or healthcare providers should be directed to ProCare Rx at 800-555-8513. If the medication will be billed for on a medical claim rather than through the pharmacy, the provider may contact the Provider Relations Department at 1-888-JAI-1999 with any questions. Our prior authorization criteria can be found on our website, www.jaimedicalsystems.com, as well as in this formulary. Any updates made to our criteria will be posted on our website within 30 days.

Please visit our website, www.jaimedicalsystems.com/providers/pharmacy/ for information about the Prior Authorization Process and Criteria. Please see Attachment T for a Prior Authorization Form.

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

Please visit our website, www.jaimedicalsystems.com/providers/pharmacy/ for the most up to date Hepatitis C clinical criteria and Prior Authorization Form.

Step Therapy and Quantity Limits

Please see Jai Medical Systems' website for information related to our formulary and any applicable step therapy and/or quantity limits. Our formulary may be found online at www.jaimedicalsystems.com/providers/pharmacy/.

Maryland Prescription Drug Monitoring Program

Jai Medical Systems complies with the Maryland Prescription Drug Monitoring Program. The Maryland Prescription Drug Monitoring Program (PDMP) is an important component of the Maryland Department of Health initiative to halt the abuse and diversion of prescription drugs. The Maryland Department of Health is a statewide database that collects prescription data on Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH) dispensed in outpatient settings. The Maryland Department of Health does not collect data on any other drugs.

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

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

Corrective Managed Care Program

We restrict members to one pharmacy if they have abused pharmacy benefits. We must follow the State's criteria for Corrective Managed Care. The Corrective Managed Care (CMC) Program is an ongoing effort by the Maryland Medicaid Pharmacy Program (MMPP) to monitor and promote appropriate use of controlled substances. Call 1-888-JAI-1999 (1-888-524-1999) if a member is having difficulty filling a prescription. The CMC program is particularly concerned with appropriate utilization of opioids and benzodiazepines. Jai Medical Systems will work with the State in these efforts and adhere to the State's Opioid preauthorization criteria.

Maryland Opioid Prescribing Guidance and Policies

The following policies apply to both Medicaid Fee-for-Service and all 9 Managed Care Organizations (MCO):

Policy

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

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

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

Guidance:

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

Providers should screen for Substance Use Disorder. Before writing for an opiate or any controlled substance, providers should use a standardized tool(s) to screen for substance use. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an example of a screening

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

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

tool.[3] Caution should be used in prescribing opioids for any patients who are identified as having any type of or history of substance use disorder. Providers should refer any patient whom is identified as having a substance use disorder to a substance use treatment program.

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

Patients Identified with Substance Use Disorder Should be Referred to Substance Use Treatment. Maryland Medicaid administers specialty behavioral health services through a single Administrative Services Organization – Optum Maryland. If you need assistance in locating a substance use treatment provider, Optum may be reached at 800-888-1965. If you are considering a referral to behavioral health treatment for one of your patients, additional resources may be accessed at maryland.optum.com .

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

For more information about the PDMP, visit the MDH website: https://health.maryland.gov/pdmp/pages/home.aspx. If you are not already a registered CRISP user you can register for **free** at https://crisphealth.force.com/crisp2_login. PDMP usage is highly encouraged for all CDS prescribers and will become mandatory to check patients CDS prescriptions if prescribing CDS at least every 90 days (by law) in July 1, 2018.

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

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

Section VI.

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

Facts to Know Before You Bill

You must verify through the Eligibility Verification System (EVS) that participants are enrolled and eligible with Jai Medical Systems before submitting claims for services.

- You are prohibited from balance billing anyone that has Medicaid including MCO members.
- You may not bill Medicaid or MCO members for missed appointments.
- Medicaid regulations require that a provider accept payment by the Program as payment in full for covered services rendered and make no additional charge to any person for covered services.
- Any Medicaid provider that practices balance billing is in violation of their contract.
- For covered services MCO providers may only bill us or the Medicaid program if the service is covered by the State but is not covered by the MCO.
- Providers are prohibited from billing any other person, including the Medicaid participant or the participant's family members, for covered services.
- HealthChoice participants may not pay for covered services provided by a Medicaid provider that is outside of their MCO provider network.
- If a service is not a covered service and the member knowingly agrees to receive a non-covered service the provider MUST notify the member in advance that the charges will not be covered under the program. A provider may require that the member sign a statement agreeing to pay for the services and place the document in the member's medical record. We recommend you call us to verify that the service is not covered before rendering the service.
- Providers rendering services to Medicaid beneficiaries must be enrolled and in an active status with Maryland Medicaid's electronic Provider Revalidation and Enrollment Portal (ePREP). To enroll with ePREP and/or update your status today, please visit Maryland Medicaid's Provider Enrollment website at https://eprep.health.maryland.gov/. If you have any questions or need assistance with ePREP enrollment, please contact the Maryland Medicaid ePREP Call Center directly at 1.844.4MD.PROV (1.844.463.7768) or via email at MDProviderRelations@automated-health.com.

  Please be advised that claims for dates of service beginning January 1, 2020 may be subject to denial and/or rejection for providers who have not yet enrolled or are not in an active status with Maryland Medicaid's ePREP system.

Submitting Claims to Jai Medical Systems

The participating provider must submit a current CMS 1500 form or UB-04 form for every covered service provided to a member by the provider. A current CMS 1500 form has a revision date of 02-12. All claims, including electronic and paper, must be submitted to Jai Medical Systems within **one hundred and eighty (180) calendar days** from the date of service. If you have any questions about a claim, please call the Jai Medical Systems Customer Service Department at 1-888-JAI-1999. For questions regarding billing procedures, please call the Jai Medical Systems Provider Relations Department at 1-888-JAI-1999.

Minimum requirement for claims submission:

- Member's Name, Sex, and Date of Birth;
- Member's Maryland Medicaid Managed Care Program I.D. Number;
- Diagnosis Code (Current ICD Codes);
- Revenue Code, Procedure Code (Current HCPCS Codes including CPT), Place of Service, Type of Bill, and Type of Service, as applicable;
- Date(s) of service (must be reported using individual dates of service; date spans are not acceptable);
- Jai Medical Systems Prior Authorization Number or Referral Number/ Copy of Authorization or Referral form;
- Rendering Provider's Name, Address, and Authorized Signature;
- Rendering Provider's NPI;
- Explanation of Payments from other insurance carrier(s) if applicable; and
- Rates and Charges (usual and customary billing charges).

Failure to submit the aforementioned information and data within the prescribed time frame of one hundred and eighty (180) calendar days from the date of service may result in payment delay and/or denial.

Paper Claims: Mail all paper claims addressed to the Jai Medical Systems Claims Department at the following address:

Jai Medical Systems Managed Care Organization, Inc.
Attn: Claims Department
301 International Circle
Hunt Valley, MD 21030

For an initial submission of an ER claim with medical records, please mail to:

Jai Medical Systems Managed Care Organization, Inc.
Attn: ER Medical Record Claims
PO Box 747
Hunt Valley, MD 21030

Electronic Claims: To submit electronic claims, please register at www.claimsnet.com/jai.

Ethical Medical Billing Practices

Providers are responsible for the accuracy of their medical billing, regardless of whether or not a medical billing company is used. It is fraudulent to submit a claim that is known to be inaccurate. It is also fraudulent to bill for a procedure or encounter that did not occur. A provider must be able to substantiate all billed procedures and diagnosis codes through appropriate medical record documentation. Jai Medical Systems, the State of Maryland, and the Office of the Inspector General reserve the right to audit all provider medical billing practices. Providers engaged in fraudulent medical billing practices are subject to legal action, including criminal prosecution and penalties. Below are examples of common types of medical billing fraud:

Upcoding – coding a diagnosis which is more severe than what the patient really has or coding a procedure that has a higher reimbursement rate than what actually occurred.

Downcoding – coding a diagnosis which is less severe than what the patient really has.

Separating Procedures/Unbundling – separating procedures that should not be separated in order to gain a higher payment

Double Billing – Billing for the same visit more than once.

Unnecessary Treatments – Providing treatments that are not medically necessary.

All providers are reminded to document in the medical record all procedures performed and all relevant diagnoses.

Third Party Recoveries

Jai Medical Systems is the payer of the last resort and the provider shall identify and bill other third-party carries or insurers first.

If a member has third-party coverage, including but not limited to Part A or B Medicare, the provider agrees to identify and seek such payment before submitting claims to Jai Medical Systems.

Claims involving third parties shall be filed in accordance with the following:

- The provider shall include a complete copy of the other third-party carrier's explanation of payments (EOP) or remittance advice (RA) when submitting a claim for a non-capitated service for the balance due under non-duplication of benefits. A claim for any balance due must be received within one hundred and eighty (180) calendar days from the date of the third-party carriers EOP.

- For Jai Medical Systems non-Medicare members, the allowed amount will be based upon Jai Medical Systems' Fee Schedule, less the paid amount of the other third-party carrier(s); any balance of which will be paid by Jai Medical Systems as non-duplication of benefits.

Billing Inquiries

Please contact the Provider Relations Department at 1-888-JAI-1999 with all billing inquiries including questions about claims submission and claim status. You may also use our provider portal at www.jaimedicalsystems.com to check claim status.

Provider Appeal of Jai Medical Systems Claim Denial

Providers may appeal claims that have paid or denied if they are not satisfied with the adjudication of the claim. Providers have one hundred and eighty (180) calendar days to submit a first level appeal from the date of Explanation of Payment (EOP) for the claim in question. Providers have thirty (30) calendar days to submit a second level appeal from the date of the first level appeal's determination letter. Providers have eighty five (85) business days to submit a third level appeal from the date that the first level appeal was received. If a provider is submitting a third level medical record review appeal, they must attach the second level appeal determination letter and all applicable medical records. Jai Medical Systems will send a written acknowledgement for all appeals received within 5 business days of receipt.

Jai Medical Systems will review appeals submitted by the provider only if the initial claim had been filed within the prescribed submission deadline. Any appeals received that do not meet the requirements outlined below may be returned to the submitting party and may not be reviewed.

All claims appeals submitted to Jai Medical Systems must include the following information:

- Cover letter explaining the reason for the appeal including:
    - Full name and Date of Birth (DOB) of the patient
    - Claim number being appealed
    - Date of Service (DOS) of the claim being appealed
    - Contact phone number and return mail address where the determination letter should be mailed. An email address is also requested, if available.
- Copy of the claim being appealed
- Copy of JMSMCO remittance advice; and
- Supporting relevant documentation.

Claims appeals should be submitted to the following addresses:

All appeals for Medical Record Review should be addressed and mailed to:

Jai Medical Systems Managed Care Organization, Inc.
Attn: Medical Record Review
P.O. Box 1650
Hunt Valley, MD 21030

All other appeals should be addressed and mailed to:

Jai Medical Systems Managed Care Organization, Inc.
Attn: Appeals Department
301 International Circle
Hunt Valley, MD 21030

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

State's Independent Review Organization (IRO)

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

MCO Quality Initiatives

The Maryland Department of Health has developed a Quality Assurance (QA) Monitoring Plan for HealthChoice. The QA Monitoring Plan includes special provider and recipient focused studies, surveys, encounter data, and complaint hotlines.

In assuring quality of care for HealthChoice members, the provider, and in some cases, the provider staff will have the following responsibilities:

- Actively participate in a*n annual quality of care review* consisting of: (1) clinically focused medical record reviews and (2) special focused studies. This audit is to be performed by any of the following: a State contracted External Quality Review Organization (EQRO) and/or Jai Medical Systems' Quality Assurance staff. The audit is to include the special needs populations.

- Actively participate in the annual State-required HEDIS audit and ensure your office is in compliance with HEDIS standards. Jai Medical Systems will regularly send compliance guidelines to ensure you are aware of these standards.

- Provide adequate administrative support for QA activities as needed.

- Provide assistance as requested in the investigation of care denials and member appeals.

- Participate in Jai Medical Systems and State surveys regarding access and the delivery of care to HealthChoice members.

- Maintain up-to-date professional qualifications and submit renewal information to Jai Medical Systems.

- Submit complete and timely encounter data within 90 days.

- Provide requested medical documentation in the timeframe specified.

- In accordance with HIPAA regulations, providers are required to supply requested information from medical records to Jai Medical Systems for quality, billing, and coordination of care purposes.

- Outreaching to members who are on your panel or are not following up with their care. Jai Medical Systems is available to help you with this.

- If contacted by a Jai Medical Systems' employee, we would appreciate a timely and courteous response to our request.

Section VII.

PROVIDER SERVICES AND RESPONSIBILITIES

Overview of Jai Medical Systems Provider Services

The Jai Medical Systems Provider Relations Department values all of the providers participating in our network. The Provider Relations Department is available to assist providers with education, general inquiries, questions, problems, and concerns via phone 1-888-JAI-1999, email providerrelations@jaimedical.com or via fax 410-433-4615.

Provider Web Portal

Participating providers are encouraged to use our Provider Portal to check member eligibility, claim status, appeal status, and much more. To begin using our Provider Portal, please visit our website: www.jaimedicalsystems.com

Provider Inquiries

Questions? Please contact us! The Jai Medical Systems Provider Relations Department is available to assist with any questions that you may have regarding claims, appeals, credentialing, etc. Our Provider Relations Department is available Monday through Friday, 9am to 6pm, by phone at 1-888-JAI-1999. In addition, Providers may submit questions at any time through our Provider Portal or via email at providerrelations@jaimedical.com. We respectfully request that providers do not transmit any protected health information via email.

Recredentialing

Jai Medical Systems requires that all Providers in our network be recredentialed at least every three (3) years. Jai Medical Systems will not make any initial or re-credentialing decisions based on a Provider's race, ethic/national identity, gender, age, or sexual orientation.
Each Provider shall complete a recredentialing application, which shall include her/his statement regarding:

i. Physical and mental health status;
ii. Lack of impairment due to chemical dependency/substance abuse;
iii. Loss of license and/or felony convictions;
iv. Loss or limitation of privileges or disciplinary action; and
v. Attestation to correctness/completeness of information provided.

Providers may utilize the Jai Medical Systems credentialing application or the application available on the Council for Affordable Quality Healthcare (CAQH) website at https://proview.caqh.org/Login/Index?ReturnUrl=%2fPR. Providers who do not complete the re-credentialing may be at risk for losing their participation status with Jai Medical Systems.

Primary Care Providers (PCPs)

The PCP serves as the entry point for access to health care services. The PCP is responsible for providing members with medically necessary covered services, or for referring a member to a specialty care provider to furnish the needed services. The PCP is also responsible for maintaining medical records and coordinating comprehensive medical care for each assigned member. Members can choose a Physician, Nurse Practitioner or Physician's Assistant as their PCP. The PCP will act as a coordinator of care and has the responsibility to provide accessible, comprehensive, and coordinated health care services covering the full range of benefits.

The PCP is required to:

- Address the member's general health needs;
- Treat illnesses
- Coordinate the member's health care;
- Promote disease prevention and maintenance of health;
- Maintain the member's health records; and
- Refer for specialty care when necessary.

If a woman's PCP is not a women's health specialist, **Jai Medical Systems** will allow her to see a women's health specialist within **the Jai Medical Systems provider network** without a referral, for covered services necessary to provide women's routine and preventive health care services. Prior authorization is required for certain treatment services.

PCP Contract Terminations

If you are a PCP and we terminate your contract for any of the following reasons, the member assigned to you may elect to change to another MCO in which you participate by calling the Enrollment Broker within 90 days of the contract termination:

- For reasons other than the quality of care or your failure to comply with contractual requirements related to quality assurance activities; or
- **Jai Medical Systems** reduces your reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to **Jai Medical Systems** by the Department, and **Jai Medical Systems** and you are unable to negotiate a mutually acceptable rate.

Specialty Providers

Specialty providers are responsible for providing services in accordance with the accepted community standards of care and practices. MDH requires **Jai Medical Systems** to maintain a complete network of adult and pediatric providers adequate to deliver the full scope of benefits. If a PCP cannot locate an appropriate specialty provider, please call **Jai Medical Systems at 1-888-JAI-1999** for assistance.

Out of Network Providers and Single Case Agreements

We understand that, at times, a member may need care from an Out of Network Provider. In these cases, Jai Medical Systems requests that the Provider submit a request for a Single Case Agreement to the Jai Medical Systems Utilization Management Department. The Single Case Agreement will be reviewed within 48 hours of receipt. After review, the Jai Medical Systems Utilization Management Department will advise the Out of Network Provider regarding their review and the outcome of the Single Case Agreement. For additional questions regarding Single Case Agreements, please contact the Utilization Management Department at 1-888-JAI-1999.

For Out of Network Providers who are interested in becoming a participating provider, please contact the Jai Medical Systems Provider Relations Department at 1-888-JAI-1999 or via email at providerrelations@jaimedical.com.

Second Opinions

If a member requests a second opinion, Jai Medical Systems will provide for a second opinion from a qualified health care professional within our network. If necessary we will arrange for the member to obtain one outside of our network.

Provider Requested Member Transfer

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

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

- The provider must send a letter informing the member of the termination and the reason(s) for the termination. A copy of this letter must also be sent to:

Jai Medical Systems MCO, Inc.
301 International Circle
Hunt Valley, MD 21030

- The provider must support continuity of care for the member by giving sufficient notice and opportunity to make other arrangements for care.

- Upon request, the provider will provide resources or recommendations to the member to help locate another participating provider and offer to transfer records to the new provider upon receipt of a signed patient authorization.

Medical Records Requirements

It is Jai Medical Systems policy that medical records are kept securely and confidentiality is maintained in accordance with HIPAA requirements.

It is the policy of Jai Medical Systems that all medical records be legible and should include the following:

- Patient Identification Information: Each page of the patient's records should include the patient's full name and either a Medical Assistance #, date of birth, or other identifying information;

- Personal Biographical Data: The record must include the patient's age, sex, address, phone number, insurance information, date of birth, start date, marital status, emergency contact, and emergency contact phone number;

- Entry Dates: All patient records will have each entry dated;

- Provider Identification: All entries into a patient record will be identified as to author;

- Allergy List: All allergies and adverse reactions should be prominently noted on the chart;

- Past Medical History, Family History, and Physical Exam: A patient's past medical history will be noted on every patient seen. For children, this should include their perinatal history and birth process;

- Immunizations: Date of immunization, lot information, immunization counseling, History including adverse reactions, seropositive results, disease history, and documentation of immunization refusal, if applicable;

- Problem List;

- Medication List;

- Substance Use List;

- Referrals including results, if applicable;

- Patient Visit Data: This should include History and Physical Examination, Plan of Treatment, Diagnostic Tests, Return Appointment / Follow Up, and LMP Documented (when appropriate); and

- Preventive Services documentation.

Medical records must be provided to Jai Medical Systems on request in a timely manner.

Confidentiality and Accuracy of Member Records

Providers must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies a **Jai Medical Systems** member. Original medical records must be released only in accordance with federal or Maryland laws, court orders, or subpoenas.

Providers must follow both required and voluntary rules related to the confidentiality of medical records which must be consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy statute and regulations (http://www.hhs.gov/ocr/privacy/).

Reporting Communicable Disease

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

- The provider report must identify the disease or suspected disease and demographics on the member including the name age, race, sex and address of residence, hospitalization,

date of death, etc. on a form provided by the Department (DHMH1140) as directed by COMAR 10.06.01.

- With respect to patients with tuberculosis, you must:
  - Report each confirmed or suspected case of tuberculosis to the LHD within 48 hours.
  - Provide treatment in accordance with the goals, priorities, and procedures set forth in the most recent edition of the Guidelines for Prevention and Treatment of Tuberculosis, published by MDH.

Other Reportable Diseases and Conditions

- A single case of a disease of known or unknown etiology that may be a danger to the public health, as well as unusual manifestation(s) of a communicable disease, are reportable to the local health department.

- An outbreak of a disease of known or unknown etiology that may be a danger to the public health is reportable immediately by telephone.

Reportable Communicable Diseases - Laboratory Providers

Providers of laboratory services must report positive laboratory results as directed by Health - General Article § 18-205, Annotated Code of Maryland.

In order to be in compliance with the Maryland HIV/AIDS reporting Act of 2007, Laboratory providers must report HIV positive members and all CD4 test results to the Health Department by using the member's name. The State of Maryland HIV/CD4 Laboratory Report Form DHMH 4492 must be used. The reporting law and the revised reporting forms may be found at the following website:

https://phpa.health.maryland.gov/Pages/reportable-diseases.aspx
Laboratories that perform mycobacteriology services located within Maryland, must report all positive findings to the Health Officer of the jurisdiction in which the laboratory is located. For out-of-state laboratories licensed in Maryland and performing tests on specimens from Maryland, the laboratory may report to the Health Officer of the county of residence of the patient or to Maryland Department of Health, Division of Tuberculosis Control within 48 hours by telephone (410) 767-6698 or fax (410) 669-4215.

Jai Medical Systems will cooperate with LHDs in investigations and control measures for communicable diseases and outbreaks.

Advance Directives

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

- Providing written information to adult members regarding each individual's rights under Maryland law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting in the member's medical record, whether or not the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member 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 member's wishes to attending staff at hospitals or other facilities.
- Educate patients on Advance Directives (durable power of attorney and living wills)

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

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

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

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.

Members are to receive covered services without concern about race, ethnicity, national origin, religion, gender, age, mental, or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English. **Jai Medical Systems** expects providers to treat all members with dignity and respect as required by federal law including honoring member's beliefs, be sensitive to cultural diversity, and foster respect for member'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.

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

Jai Medical Systems is required to verify that Limited English Proficient (LEP) members have meaningful access to health care services. Because of language differences and inability to speak or understand English, LEP persons are often excluded from programs they are eligible

for, experience delays, denials of services, receive care, services based on inaccurate or incomplete information. Providers must deliver services in a culturally effective manner to all members, including those with limited English proficiency (LEP) or reading skills.
Please note that Interpreter services are available for all Jai Medical Systems members regardless of their primary spoken language. Interpreter services also provide assistance to those who are deaf, hard of hearing, or have difficulty speaking.

To request an interpreter for a Jai Medical Systems member, please contact the Jai Medical Systems Customer Service Department at 1-888-JAI-1999.

Individuals who are deaf, hard of hearing, or have difficulty speaking can use the Maryland Relay Service (711).

Access for Individuals with Disabilities

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

Section VIII.

QUALITY ASSURANCE MONITORING PLAN
AND
REPORTING FRAUD, WASTE AND ABUSE

Quality Assurance Monitoring Plan

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

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

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

To report these measures to MDH, **Jai Medical Systems** must perform chart audits throughout the year to collect clinical information on our Members. **Jai Medical Systems** truly appreciates the provider offices' cooperation when medical records are requested.

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

Fraud, Waste and Abuse Activities

Jai Medical Systems takes matters regarding fraud, waste, and abuse seriously. Jai Medical Systems reports suspected fraud, waste, and abuse, including concerns related to fraud, integrity, or patient safety, to the Maryland Department of Health Office of the Inspector General.

Examples of Fraud and Abuse:

- Anyone who forges a physician's signature on a prescription medication or uses a physician's name to call a false prescription in to the pharmacy.
- Anyone who lies about having lost prescription medication.
- Anyone who gets prescription medication when they are not ill.
- Someone who used or is currently using a medical ID card that does not belong to them.
- Any member who excessively overutilizes emergency services when not necessary.
- A Provider who bills for services not rendered.

If you are suspected of committing fraud and/or abuse by Jai Medical Systems Managed Care Organization, Inc., you will be submitted to the Maryland Department of Health– Office of Inspector General (MDH-OIG) for further investigation.

Reporting Suspected Fraud and Abuse

Participating providers are required to report to **Jai Medical Systems** all cases of suspected fraud, waste and abuse, inappropriate practices, and inconsistencies of which they become aware within the Medicaid program.

To Report Fraud and Abuse, please contact our Customer Service Department and request to speak with our Fraud and Abuse Compliance Officer:

1-888-JAI-1999

Or write to:
Fraud and Abuse Compliance Officer
Jai Medical Systems
301 International Circle
Hunt Valley, MD 21030

You may also report provider fraud to the MDH Office of the Inspector General at **410-767-5784 (or 1-866-770-7175**), the Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General, at **410-576-6521** (**1-888-743-0023**) or to the Federal Office of Inspector General in the U.S. Department of Health and Human Services at **1-800-HHS-TIPS (1-800-447-8477).**

The Maryland Medicaid Fraud Control Division of the Office of the Maryland Attorney General created by statute to preserve the integrity of the Medicaid program by conducting and coordinating Fraud, Waste, and Abuse control activities for all Maryland agencies responsible for services funded by Medicaid.

Relevant Laws

There are several relevant laws that apply to Fraud, Waste, and Abuse:

The Federal False Claims Act (FCA) (31 U.S.C. §§ 3729-3733) was created to combat fraud & abuse in government health care programs. This legislation allows the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $11,000 per false claim. The False Claims Act prohibits, among other things:

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

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

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

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

The Health Insurance Portability and Accountability Act (HIPAA) requires:

- Transaction standards
- Minimum security requirements
- Minimum privacy protections for protected health information
- National Provider Identification (NPIs) numbers

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

Under the Federal Anti-Kickback statute (AKA), codified at 42 U.S.C. § 1320a-7b, it is illegal to knowingly and willfully solicit or receive anything of value directly or indirectly,

overtly or covertly, in cash or in kind, in return for referring an individual or ordering or arranging for any good or service for which payment may be made in whole or in part under a federal health care program, including programs for children and families **accessing Jai Medical Systems** services through Maryland HealthChoice.

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

Under the Maryland False Claims Act, Md. Code Ann., Health General §2-601 et. seq.
Administrative sanctions can be imposed, as follows:

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

Remediation may include any or all of the following:

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

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

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

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

Attachments

Attachment A:
School-Based Health Center
Health Visit Form

SCHOOL-BASED HEALTH CENTER HEALTH VISIT REPORT FORM

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

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

Age: **Chief Complaint:**
HPI:

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

Physical Findings:

General: ☐ Alert/NAD
☐ Pertinent:

Head: ☐ Normal
☐ Pertinent:

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

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

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

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

Neck: ☐ Full ROM. No tenderness
☐ Pertinent:

Lymph Nodes: ☐ No lymphadenopathy
☐ Pertinent:

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

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

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

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

Extremities: ☐ FROM
☐ Pertinent:

Neurologic: ☐ Grossly intact
☐ Pertinent:

Skin: ☐ Intact, no rashes
☐ Pertinent:

ASSESSMENT: **PLAN:**

Rx Ordered:

Labs Ordered:

Radiology Services Ordered:

PCP F/U Required:
☐ **Yes** ☐ **No**

Provider Signature: _____

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

Attachment B:
Local Health Services
Request Form

LOCAL HEALTH SERVICES REQUEST FORM
INSTRUCTIONS

PURPOSE: This form is intended for use by the Managed Care Organization [MCO] to refer clients in need of outreach and health-related services to the Local Health Department Administrative Care Coordination Unit [LHD-ACCU]. The assistance of the Local Health Department may be requested only after the MCO has made documented attempts to contact and bring into care a recipient who is difficult to reach or misses appointments. (COMAR 10.09.66.03B)

INSTRUCTIONS FOR USE:

1. **'TO'** - Fill in the appropriate Local Health Department based on the client's county of residence.
2. **'FROM' –** Indicate the referral source including contact name, address, phone number and fax number
3. **'CLIENT NAME' –** Provide client demographic information, MA number and last known address and phone number[s]
4. **'FOLLOW-UP' –** Indicate the client's population category [FOR] and the reason for the request [Related To]. Please add additional information or comments that may assist the LHD to outreach the member.

MCO Section:

- Indicate the type and number of outreach attempts (letters, phone calls, face-to-face)
- Provide the health care provider name and phone number
- Add any additional information under "Comments" that may assist the LHD to outreach the member i.e. full name and contact information of the Head of Household/Guardian; potential need for interpreter services; diagnosis/treatment; EDC; date of most recent contact between MCO and client and/or provider.
- Forward the top copy to the LHD-ACCU [LHD addresses attached]

Local Health Department Section:

- Indicate the action taken
- Include any additional case findings under "Comments" that may assist the MCO in providing on –going care coordination for the client
- Return the appropriate copy to the MCO/Provider

SELECTED DEFINITIONS:

MISSED APPOINTMENTS:

- Child under 2years who has missed two consecutive EPSDT appointments
- Child 2-21 years who has missed two consecutive appointments and is in need of treatment
- Pregnant woman who is thirty days past appointment date.
- Adult meeting 'special needs' criteria who has missed three consecutive appointments for treatment.

ADDHERENCE TO PLAN OF CARE:

- Non-compliance with treatment plan or medical regime.

IMMUNIZATION DELAY:

- 60 days past immunization due date

PREVENTABLE HOSPITALIZATION:

- Inpatient care within the preceding 60 days for dehydration, pneumonia, burns, cellulitis, 'Failure to Thrive', lead poisoning, ingestion, intentional injuries

OTHER:

- Additional information that will assist the LHD with care coordination.

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

HealthChoice
LOCAL HEALTH SERVICES REQUEST FORM

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

MCO:	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) _____ # Face to Face _____	☐Unable to Locate ☐Contact Date: / / ☐Advised ☐Refused
Comments:	
Contact Person: Phone: Fax:	Provider Name: Provider Phone:

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

LOCAL HEALTH SERVICES REQUEST FORM

INSTRUCTIONS FOR USE:

1.) **Purpose:** This form is to be used by PMP/ MCO to refer clients in need of outreach and health-related services to the LHD-ACCU.
2.) **To:** Fill in the appropriate local health department based on the client's county of residence.
3.) **From:** Indicate the referral source including, mailing address, contact name, phone number, and fax number.
4.) **Client Name:** Provide demographic information, MA number, last known address and phone number.
5.) **Follow-up:** Indicate the population category (FOR) and the reason for the request (Related To) Please add additional information or comments, that may assist the LHD to outreach member.

MCO Section:
Indicate type and number of outreach attempts; forward top copy to LHD-ACCU. Please indicate provider name and phone number. Please add additional information/comments that may assist the LHD to outreach member.

LHD Section:
Indicate action taken and return the appropriate copy to the MCO/Provider.

SEND REFERRALS TO:

Allegany Co. Hlth. Dept.- ACCU
12501 Willowbrook Rd. S.E. (301) 759-5094
Cumberland, MD 21502 (fax) 301-777-2401

Anne Arundel Co. Hlth. Dept. - ACCU
3 Harry S. Truman Pkwy. HD #8 (410) 222-7541
Annapolis, MD 21401 (fax) 410-222-4150

Baltimore Co. Hlth. Dept. - ACCU
6401 York Rd (410) 887-8741
Baltimore, MD 21212 (fax) 410-828-8346

Calvert Co. Hlth. Dept. - ACCU
975 Solomons Island Rd. North, (410) 535-5400
Prince Frederick, MD 20678 (fax) 410-535-1955

Caroline Co. Hlth. Dept. - ACCU
403 S. Seventh Street (410) 479-8023
Denton, MD 21629 (fax) 410-479-4871

Carroll Co. Hlth.Dept. - ACCU
290 S. Center Street (410) 876-4941
Westminster, MD 21157 (fax) 410-876-4959

Cecil Co. Hlth. Dept. - ACCU
401 Bow Street (410) 996-5145
Elkton, MD 21921 (fax) 410-996-0072

Charles Co. Hlth. Dept. - ACCU
4545 Crain Hwy. (301) 609-6803
White Plains, MD 20695 (fax) 301-934-7048

Dorchester Co. Hlth. Dept. - ACCU
3 Cedar Street (410) 228-3223
Cambridge, MD 21613 (fax) 410-228-8976

Frederick Co. Hlth. Dept. - ACCU
350 Montevue Lane (301) 600-3341
Frederick, MD 21702 (fax) 301-600-3302

Garrett Co. Hlth. Dept. - ACCU
1025 Memorial Dr. (301) 334-7692
Oakland, MD 21550 (fax) 301-334-7771

Harford Co. Hlth. Dept. - ACCU
Aberdeen Health Ctr. (410) 273-5626
34 North Philadelphia Blvd. (fax) 410-272-5467
Aberdeen, MD 21001

Howard Co. Hlth. Dept. - ACCU
8930 Stanford Blvd (410) 313-7323
Columbia, MD 21045 (fax) 410-313-5838

Kent Co. Hlth. Dept. -ACCU
125 S. Lynchburg St. (410) 778-7035
Chestertown, MD 21620 (fax) 410-778-7019

Montgomery Co. Hlth. Dept - ACCU
1335 Piccard Drive, 2nd Floor (240) 777-1648
Rockville, MD 20850 (fax) 240-777-4645

Prince Georges' Co. Hlth. Dept.- ACCU
9314 Piscataway Road 301-856-9550
Clinton, MD 20735 (fax) 301-856-9628

Queen Anne's Co. Hlth. Dept.- ACCU
206 N. Commerce S treet (443) 262-4481
Centreville, MD 21617 (fax) 443-262-9357

St. Mary's Co. Hlth. Dept.- ACCU
21580 Peabody Street (301) 475-4951
Leonardtown, MD 20650-0316 (fax) 301-475-4350

Somerset Co. Hlth. Dept.- ACCU
7920 Crisfield Hwy. (443) 523-1740
Westover, MD 21871 (fax) 410-651-2572

Talbot Co. Hlth. Dept.- ACCU
100 S. Hanson Street (410) 819-5600
Easton, MD 21601-0480 (fax) 410-819-5683

Washington Co. Hlth. Dept. - ACCU
1302 Pennsylvania Avenue (240) 313-3229
Hagerstown, MD 21742 (fax) 240-313-3222

Wicomico Co. Hlth. Dept.- ACCU
108 E. Main Street (410) 543-6942
Salisbury, MD 21801 (fax) 410-543-6568

Worcester Co. Hlth. Dept.-ACCU
9730 Healthway Dr (410) 629-0164
Berlin, MD 21811 (fax) 410-629-0185

Healthcare Access Maryland
201 E. Baltimore Street #1000 (410) 649-0500
Baltimore, MD 21202 (fax) 410-649-0532

DHMH 4582 rev. 5/14
1-800-456-8900

Attachment C:
Maryland Healthy Kids
Schedule of
Preventive Health Care

Wellness Schedule for Children

The table below shows the ages that children need well child visits. If your child's Primary Care Provider (PCP) recommends more visits they will also be covered. During well child visits the PCP will check your child's health and all aspects of development. They will also check for problems through screening. Some screenings for health problems are done through blood work while others are done by asking questions. Additional screens may be required based on age and risk. The PCP will also offer advice and tell you what to expect. Make sure you keep appointments for well-child exams. Do not miss immunizations and make sure children get their blood tested for lead. Lead in the blood causes serious problems so testing is required for all children regardless of risk.

Age	**Well Child Exam Assess Development Health Education**	**Childhood Immunizations** **(*influenza recommended every year starting at 6 months of age)**	**Blood Lead test** **(*additional if at risk)**
Birth	**X**	**X**	
3-5 days	**X**		
1 month	**X**		
2 months	**X**	**X**	
4 months	**X**	**X**	
6 months	**X**	**X**	
9 months	**X**		
12 months (1 year)	**X**	**X**	**X**
15 months	**X**	**X**	
18 months (1.5 years)	**X**	**X**	
24 months (2 years)	**X**		**X**
30 months (2.5 years)	**X**		
36 months (3 years)	**X**		
4-20 years	**X** (yearly)	**X** (ages 4-6, 9-12 and 16)	

Maryland Healthy Kids Preventive Health Schedule

Components		Infancy (months)							Early Childhood (months)							Late Childhood (yrs.)								Adolescence (yrs.)							
Health History and Development		**Birth**	**3-5 d**	**1**	**2**	**4**	**6**	**9**	**12**	**15**	**18**	**24**	**30**	**36**	**48**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
Medical and family history/update		X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Peri-natal history		X	X	X	→	→	→	→	→	→	→																				
Psycho-social/environmental assessment/update		X	X	X	→	→	→	→	X	→	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Surveillance (Subjective)			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Screening (Standard Tools)[1]								X	→	→	X	X	→																		
Autism Screening											X	X	→																		
Mental health/behavioral assessment														X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Substance use assessment																						X	X	X	X	X	X	X	X	X	X
Depression Screening																						X	X	X	X	X	X	X	X	X	X
Maternal Depression Screening				X	X	X	X																								
Physical Exam																															
Systems exam		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vision/hearing assessments[2]		O[2]	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	S	O	S	O	S	O	S	S	O	S	S	O	S	S
Oral/dentition assessment		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition assessment		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Measurements and graphing:	Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X
	Head Circumference	X	X	X	X	X	X	X	X	X	X	X																			
	BMI											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X
Blood Pressure[3]														X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Risk Assessments by Questionnaire																															
Lead assessment by questionnaire							X	X	X	X	X	X	X	X	X																
Tuberculosis *				X	→	→	X	→	X	→	→	X	→	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Heart disease/cholesterol *												X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Sexually transmitted infections (STI) *																						X	X	X	X	X	X	X	X	X	X
Anemia *																						X	X	X	X	X	X	X	X	X	X
Laboratory Tests																															
Newborn Metabolic Screening		X		X	→																										
Blood lead Test									X	→	→	X	→	→	→	→															
Anemia Hgb/Hct									X	→	→	X	→	→	→	→															
Dyslipidemia Test																				X	→	→						X	→	→
HIV Test																									X	→	→	→			
Immunizations																															
History of immunizations		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vaccines given per schedule		X	→	→	X	X	X	→	X	X	X	→	→	→	→	→	→	→	→	→	→	X	X	→	→	→	→	→	→	→	→
Fluoride Varnish Program[4]								X	X	X	X	X	X	X	X	X															
Health Education																															
Age-appropriate education/guidance		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counsel/referral for identified problems		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental education/referral									X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Scheduled return visit		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Key : X Recommended; → Recommended if not previously done; S Subjective by history /observation; O Objective by standardized testing; * Counseling/testing recommended when positive

The Schedule reflects minimum standards required for all Maryland Medicaid recipients from birth to 21 years of age. The Maryland Healthy Kids Program requires yearly preventive care visits between ages 3 years through 20 years. [1]Refer to AAP 2006 Policy Statement referenced in the Healthy Kids Program Manual.-Screening required using standardized tools. [2]Newborn Hearing Screen follow-up recommended for abnormal results. [3]Blood Pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years. [4]The fluoride varnish may be administered by either a primary care provider or a dentist.

Attachment D:
Local Health Department
Healthy Start Contacts

Maryland Local Health Departments
Administrative Care Coordinators Units (ACCU) Contact Information

County	Contact Information	County	Contact Information
Allegany	P.O. Box 1745 12501 Willowbrook Road S.E. Cumberland MD 21502 Tel. (301) 759-5094; Fax (301) 777-2401	Howard	8930 Stanford Blvd. Columbia, MD 21045 Tel. (410) 313-7567: Fax (410) 313-5838
Anne Arundel	3 Harry S, Truman Pkwy., HD 25 Annapolis, MD 21401 Tel. (410) 222-7541 Fax (410) 222-4140	Kent	125 S. Lynchburg Street Chestertown, MD 21620 Tel. (410) 778-7035; Fax (410) 778-7019
Baltimore County	6401 York Road, 3rd Floor Towson, Maryland 21212 Tel. (410) 887-4381; Fax (410) 828-8346	Montgomery	1335 Piccard Drive, 2nd fl Rockville, MD 20850 Tel. (240) 777-1648; Fax (240) 777-4646
Calvert	975 N. Solomon Islands Road, N. Prince Frederick, MD 20678 Tel. (410) 535-5400 ext.360; Fax 410-535-1955	Prince George's	9314 Piscataway Road Clinton, MD 20735 Tel. (301) 856-9494; Fax (301) 856-9628
Caroline	403 S. Seventh Street Denton, MD 21629 Tel. (410) 479-8023; Fax (410) 876-4959	Queen Anne's	206 N. Commerce Street Centerville, MD 21617 Tel. (443) 262-4481; Fax (443) 262-9357
Carroll	290 S. Center Street Westminster, MD 21157 Tel. (410) 876-4940; Fax (410) 996-0072	St. Mary's	21580 Peabody Street Leonardtown, MD 20650 Tel. (301) 475-4951; Fax (301)475-4350
Cecil	401 Bow Street Elkton, MD 21921 Tel. (410) 996-5145; Fax (410) 996-0072	Somerset	7920 Crisfield Hwy Westover, MD 21871 Tel. (443) 523-1764; Fax (410) 651-2572
Charles	4545 Crain Hwy White Plains, MD 20695 Tel. (301) 609-6803; Fax (301) 934-7048	Talbot	100 S. Hanson Street Easton, MD 21601 Tel. (410) 819-5654; Fax (410) 819-5683
Dorchester	3 Cedar Street Cambridge, MD 21613 Tel. (410) 228-3223; Fax 410-228-8976	Washington	1302 Pennsylvania Avenue Hagerstown, MD 21742 Tel, (240) 313-3290; Fax (240) 313-3299
Frederick	350 Montevue Lane Frederick, MD 21702 Tel. (301) 600-3341; Fax (301) 600-3302	Wicomico	108 E. Main Street Salisbury, MD 21801 Tel. (410} 543-6942; Fax (410) 543-6568
Garrett	1025 Memorial Drive Oakland, MD 21550 Tel. (301) 334-7692; Fax (301) 334-7771	Worcester	424 W. Market Street Hill, MD 21811 Tel. (410) 632-9230; Fax (410) 632-9239
Harford	34 N. Philadelphia Blvd Aberdeen, MD 21001 Tel. (410) 273-5626; Fax (410) 272-5467	Baltimore City	201 E. Baltimore Street, #1000 Baltimore, MD 21202 Tel. (410) 649-0521; Fax (410) 649-3553

LDSS Out-of-Home Placement Contact List

County	Name and Title	Office Number	Address	Updated	Email	MCO Presentation Type for Permanency Staff
Allegany	Lori Pfeifer, Out of Home Caseworker	301-784-7231	1 Frederick Street, Cumberland, 21502	3/11/20	Lori.pfeifer@maryland.gov	Webinar
Anne Arundel	***Anne Arundel Foster Care Supervisors***		80 West Sreet, Annapolis, MD 21401	5/8/20		
	Terri Lowther	410-269-4772			terri.lowther@maryland.gov	
	Natalie Gimperling	410-269-4715			natalie.gimperling@maryland.gov	
	Charonne Randall	410-887-3931			charonne.randall@maryland.gov	
	Theresa Kelly	410-897-3904			theresa.kelly1@maryland.gov	
Baltimore City/MATCH Program	Deborah Logan/ New Entrant Team Supervisor	443-423-5974	1510 Guilford Avenue, Baltimore, MD 21202	5/13/20	Deboraha.Logan@maryland.gov	
Baltimore City	Janet Bridge, LCSW-C	443-423-4412	3007 E. Biddle Street, Baltimore, MD 21213	5/4/2020	janet.bridges.maryland.gov	
Baltimore County	Stephanie Meyer/Unit Supervisor Gary Sappington	410-853-3158 410-853-3161	6401 York Rd, 2nd Floor. Baltimore, 21212		stephanie.meyer@maryland.gov garry.sappington@maryland.gov	
Calvert	Sarah Utz, LMSW, Placement & Permanency Supervisor	443-550-6966	200 Duke Street, Prince Frederick 20678	3/12/20	sarah.Utz@maryland.gov	Presentation
Caroline	Heather Ruark, LCSW, Foster Care and Adoptions Supervisor	410-819-4352	207 South Third Street, Denton, 21629	3/11/20	heather.ruark1@maryland.gov	
Carroll	Peg Ryan, LCSW-C// Foster Care Supervisor	410-386-3386	1232 Tech Court, Westminister 21157		peg.ryan@maryland.gov	
	Carrie Vincent, LCSW-C/Adminstrator Foster Care Unit	410-386-3436			carrie.vincent@maryland.gov	
Cecil	Tina Linkous, LCSW/ Out of Home Administrator	4109960196	170 East Main Street. Elkton, 21921	5/7/2020	Tina.linkous@Maryland.Gov	Webinar
Charles	Jason Hartley, LCSW-C Placement and Permanency Supervisor	301-392-6751	200 Kent Avenue LaPlata 20646	5/8/2020	jason.hartley@maryland.gov	Webinar
Dorchester	Megan Murphy, LCSWC, Out of Home Supervisor	410-330-6878	627 Race Street Cambridge, 21613	5.7.20	megan.yowell@maryland.gov	Webinar
Frederick	Brenda Alwine/ Foster Care Supervisor	301-600-2624	1888 North Market Street, Frederick 21701	5/8/20	brenda.alwine@maryland.gov	
Garrett	Jessica Savage - Foster Care Supervisor	301-533-3040	12578 Garrett Highway, Oakland 21550	4/29/20	Jessica.Savage@maryland.gov	Presentation
Harford	Tawana Nolan, Out of Home Administrator	410-836-4934	2 S. Bond Street, Suite 301, Belair, MD 21014	4/30/20	tawana.nolan@maryland.gov	Webinar
Howard	Lynn Brinker, Out of Home Supervisor	410-872-8809	9780 Patuxent Woods Dr., Columbia, MD 21046	4/30/20	lynn.brinker@maryland.gov	Webinar
	Kathleen Jackson, Out of Home Administrator	410-872-8808		4/30/20	kathleen.jackson@maryland.gov	Webinar
	Mike Demidenko, Assistant Director - Please CC: in all communications	410-872-8264		4/30/20	mike.demidenko@maryland.gov	Webinar
Kent	Nikki Strong, LCSW-C, Out of Home Supervisor	410-810-7654	350 High Street Chestertown 21620	5/4/20	nikki.strong@maryland.gov	Webinar
Montgomery	Kristine Rodgers, Foster Care Supervisor	240-777-1505	1301 Piccard Drive, Rockville, Maryland 20850	5/13/2020	kristine.rodgers@montgomerycountymd.gov	Webinar
Prince George's	Darquita Fletcher, LCSW-C/Deputy Assistant Director- Please Cc: in all communications	301-909-2110	925 Brightseat Road, Landover, MD 20785		darquita.fletcher@maryland.gov	webinar
Prince George's	Imani Booker, LCSW-C,/Program Manager Foster Care	301-909-2414			imani.booker@maryland.gov	webinar
Queen Anne's	Dan Johnson, LCSW-C Out of Home Supervisor	443-254-5418	125 Comet Drive, Centreville 21617	5/7/20	dan.johnson@maryland.gov	Webinar
	Jenifer DuBosq, Assistant Director-Please cc: in all communications	410-714-3050			jenifer.dubosq@maryland.gov	
St Mary's	Angela Sacks, EA to the Director, Agency Ombudsman	240-895-7174	23110 Leonard Hall Drive, Leonardtown, 20650	5/13/20	angela.sacks@maryland.gov	Webinar
Somerset	Andrea DePrima, LCSW-C, Out of Home Supervisor	410-677-4387	30397 Mt. Vernon Road, Prince Anne 21853	3/11/20	andrea.deprima@maryland.gov	Webinar
Talbot	Christine Abbatiello, LCSW-C, Out of Home Supervisor	410-820-7185	301 Bay Street, Easton, 21601	3/11/20	christine.abbatiello@maryland.gov	
Washington	Julia Jensen, LCSW-C, Out of Home Program Manager	240-420-2189	122 North Potomac Street, Hagerstown, 21740	3/11/20	julia.jensen@maryland.gov	Presentation
Wicomico	Kelly Myrer OOH Admin	410 713-3900	201 Baptist Street, Suite 27 Salisbury 21801		kelly.myrer@maryland.gov	Webinar
	Jennifer Stack Foster Care Sup	410 713-3900			jennifer.stack@maryland.gov	Webinar
Worcester	Tammy Jones, Out of Home Supervisor	410-677-6834	299 Commerce Street, Snow Hill, 21863		tammy.jones@maryland.gov	Webinar
State: DHS, SSA	Shawnett Mills, LCPC/Well-Being Unit	410-767-7713	311 W Saratoga Street 21201		shawnett.mills1@maryland.gov	
State MCO Liaison	Henrietta Inegbenebor, Nursing Program Consultan	410 767-6206	Preston Street		henrietta.inegbenebor@maryland.gov	

Updated 3/11/20 sfranklin

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	www.alleganyhealthdept.com
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	www.aahealth.org
Baltimore City	410-396-4398~~410-396-3835~~	410-396-7633~~410-396-6422~~	410-649-50000~~521~~	https://health.baltimorecity.gov
Baltimore County	410-887-2243	410-887-2828	410-887-4381	www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	www.calverthealth.org
Caroline	410-479-8000	410-479-8014	410-479-8189~~023~~	www.carolinehd.org
Carroll	410-876-2152	410-876-4813	410-876-4941~~0~~	https://cchd.maryland.gov
Cecil	410-996-5550	410-996-5171	410-996-5130~~45~~	https://cecilcountyhealth.org
Charles	301-609-6900	301-609-6923~~7917~~	301-609-6760~~803~~	www.charlescountyhealth.org
Dorchester	410-228-3223	410-901-2426	410-9018167~~228-3223~~	www.dorchesterhealth.org
Frederick	301-600-1029	301-600-31241~~725~~	301-600-31243~~341~~	http://health.frederickcountymd.gov
Garrett	301-334-7777	301-334-7727~~9431~~	301-334-7771~~695~~	https://garretthealth.org
Harford	410-838-1500	410-638-1671	410-942-7999	https://harfordcountyhealth.com/
Howard	410-313-6300	877-312-6571	410-313-7323~~567~~	www.howardcountymd.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	www.kenthd.org
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1635~~48~~	www.montgomerycountymd.gov/hhs/
Prince George's	301-883-7879	301-856-9555	301-856-9550	www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4456~~81~~	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-4330~~6772~~	www.smchd.org
Somerset	443-523-1700	443-523-1722	443-523-1758~~66~~	http://somersethealth.org
Talbot	410-819-5600	410-819-5609	410-819-5600~~54~~	https://health.maryland.gov/talbotcounty/Pages/home.aspx
Washington	240-313-3200	240-313-3264	240-313-3292~~20~~	https://washcohealth.org
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	https://www.wicomicohealth.org/
Worcester	410-632-1100	410-632-0092	410-629-0614~~632-9230~~	http://www.worcesterhealth.org/

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Attachment E:
Hospital Report
of Newborns Form

[1]DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MARYLAND MEDICAL ASSISTANCE PROGRAM

HOSPITAL REPORT OF NEWBORNS

DHMH USE ONLY	**FAX FORM IMMEDIATELY TO:**	**OR**	**MAIL FORM TO:**
Date Received: _____	**Division of Recipient Eligibility**		**Division of Recipient Eligibility**
Date Processed: _____	**410-333-7012**		**201 West Preston Street**
Processed By: _____			**Room SS7C**
			Baltimore, Maryland 21201

Mother's Name: _____ DOB: ___/___/___
(Last) (First) (M.I.)

Mother's Medical Assistance Number: ___/___/___/___/___/___/___/___/___/___/___/

Address: _____ S.S.#: ___ ___ ___/___ ___/___ _____

City: _____ State: _____ Zip Code: _____

Full Name of Newborn (s) Last	First	MI	Date of Birth Month/ Day/ Year	Sex M or F	Birth Weight	Race
(A)			/ /		grams	
(B)			/ /		grams	

DHMH Use Only: MA Number Assigned: (A) _____

(B) _____

Name of Mother's MCO: _____

Complete Name of Hospital: _____

Address: _____ Telephone #: _____

_____ _____ _____
Printed Name of Person Completing Form | Signature of Person Completing Form | Date of Completion

Optional

Has parent selected pediatrician for ongoing care after discharge? Yes ❑ No ❑

Name: _____ Practice Name: _____

Address: _____

Note: Automatic eligibility for the newborn(s) is dependent on the mother being eligible for and receiving Medical Assistance at the time of the child's or children's birth and the child living with the mother. It is advisable to confirm the mother's eligibility status on the date of delivery by using the Eligibility Verification System (EVS). Do not submit this form if the child will not be discharged to the mother.

Attachment F:
Jai Medical Systems
Referral Form & Maryland Uniform
Consultation Referral Form

Jai Medical Systems Managed Care Organization, Inc.

REFERRAL FORM

Please Print Legibly | 1-888-JAI-1999 | ICN: *Do Not Cover ICN #*

MEMBER INFORMATION:

Name: _____ (Last) _____ (First) _____ (MI)

Date of Birth: _____

Member ID#: _____

Phone#: _____

NOTICE: Please confirm this member's enrollment status with JMSMCO using the Maryland Medicaid EVS system prior to performing any health care services. JMSMCO will not be responsible for payment of services rendered to a member who is not eligible on the date of service or for non-covered benefits. To verify eligibility, call the Maryland Medicaid EVS system at 1-866-710-1447 or visit www.emdhealthchoice.org.

REFERRAL FROM:

Primary Care Provider Office Stamp

Referring PCP: _____ (Print Legibly)

Referring PCP Address: _____

Referring PCP NPI#: _____

Date Referral Issued: _____ (Do NOT back date)

Referring PCP Signature: _____ (Do NOT pre-sign)

*This Referral is **VALID** for 90days*

Referral is VALID for contracted participating providers and limited outpatient services ONLY. This Referral is not valid for any inpatient services or any procedures requiring pre-certification or prior authorization. Please call JMSMCO's Utilization Management Department for authorization of procedures requiring pre-certification or prior authorization.

REFERRAL TO:

First Name | Last Name | Organization | Specialty

Street Address | City | State | Zip

Phone# | Fax# | Referred to Organization or Provider's NPI#

REASON FOR REFERRAL:

Primary Diagnosis: _____

Diagnosis Code: _____ _____ _____ . _____ _____

Brief Patient History:

_____

_____

Procedure to be Performed

(Not valid for procedures requiring Pre-Certification or Prior Authorization.)

Procedure# 1 : _____

CPT Code: _____ - _____

Procedure# 2: _____

CPT Code: _____ - _____

Number of Visits: _____ (If blank, one assumed)

Number of Services: _____

Note: A new referral must be executed every 90 days.

TYPE OF REFERRAL:

☐ STANDARD

☐ **URGENT** *(Contact with referring PCP by Specialist is mandatory within 3 business days of referral appointment.)*

SERVICES DESIRED: (Provide care as indicated)

☐ Consultation Only

☐ Consultation with Specific Procedures

☐ (specify in spaces provided in box on left)

☐ Diagnostic Testing (specify): _____

☐ Specific Treatment: _____

☐ Global OB Care

☐ Case Management

☐ Health Education

Other (explain): _____

PLACE OF SERVICE: (*Specific facility must be named)

☐ Office

☐ Outpatient Medical / Surgical Center:*

☐ Radiology

☐ Other (explain): _____

APPOINTMENT:

Date: _____ Time: _____ **AM/PM**

Address: _____

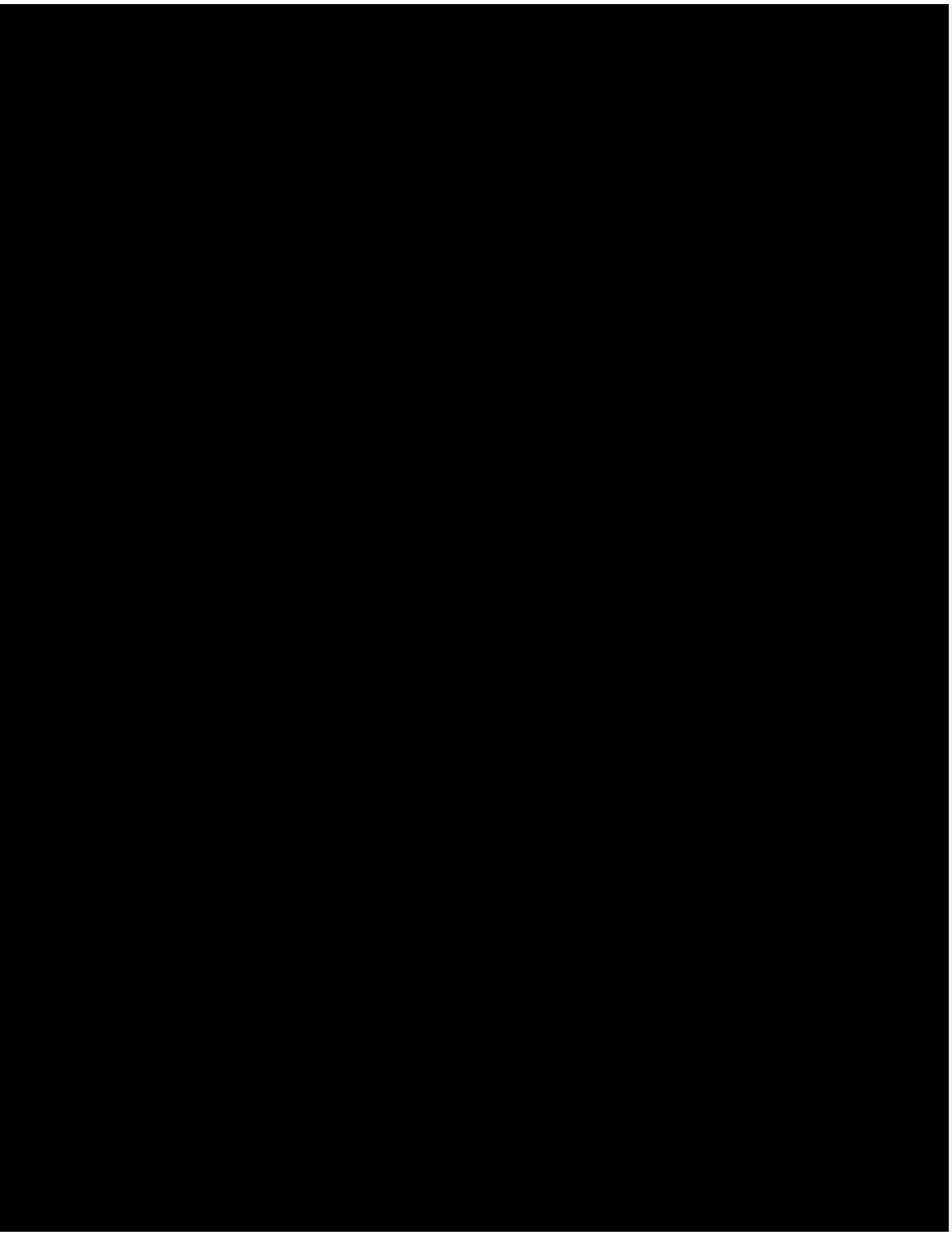
Note: A separate referral must be used for each provider or group.

First Page: PCP Copy & Fax to JMSMCO Referral Fax 1-866-381-7200 **Second Page: Member Copy / Specialist Copy**

PLEASE SEE REVERSE FOR BILLING INSTRUCTIONS AND REFERRAL RESTRICTIONS.
REFERRAL ISSUANCE IS NOT A GUARANTEE OF PAYMENT. PARTICIPATING PROVIDER STATUS MAY AFFECT PAYMENT.

JMSMCO does not employ the providers participating in our network. Participating providers in the JMSMCO network are not the actual or apparent agents ofJMSMCO. Participating providers are independent and not controlled, operated, owned, or directed by JMSMCO.

Rev. 1/18



Maryland Uniform Consultation Referral Form

Date of Referral:	Carrier Information:
Patient Information:	Name:
Name: (Last, First, MI)	Address:
Date of Birth: (MM/DD/YY) / Phone: ( )	Phone Number: ( )
Member #:	Facsimile/Data #: ( )
Site #:	

Primary or Requesting Provider:

Name: (Last, First, MI)		Specialty:
Institution/Group Name:	Provider ID #: 1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number: ( )	Facsimile/Data Number: ( )	

Consultant/Facility Provider:

Name: (Last, First, MI)		Specialty:
Institution/Group Name:	Provider ID #: 1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number: ( )	Facsimile/Data Number: ( )	

Referral Information:

Reason for Referral:	
Brief History, Diagnosis, and Test Results: *(Include ICD-9)*	
Services Desired: Provide Care as indicated: ☐ Initial Consultation Only: ☐ Diagnostic Test: (specify) _____ ☐ Consultation With Specific Procedures: (specify) _____ ☐ Specific Treatment: _____ ☐ Global OB Care & Delivery ☐ Other: (Explain)	**Place of Service:** ☐ Office ☐ Outpatient Medical/Surgical Center * ☐ Radiology ☐ Laboratory ☐ Inpatient Hospital * ☐ Extended Care Facility * ☐ Other: (Explain) * (Specific Facility Must be Named.)
Number of Visits: _____ . If Blank, 1 Visit is Assumed. / Authorization #: (If Required)	Referral is Valid Until: (Date) _____ . (See Carrier Instructions)
Signature: (Individual Completing This Form)	Authorizing Signature: (If Required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan / carrier.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Carrier/Plan Manual for Specific Instructions.

Attachment G:
Pre-Certification
Procedure List

JAI MEDICAL SYSTEMS MANAGED CARE ORGANIZATION, INC.

SERVICES AND PROCEDURES REQUIRING PRIOR AUTHORIZATION

Jai Medical Systems Managed Care Organization, Inc. (JMSMCO) requires prior authorization for the services and procedures listed below. All requests must go through the PCP office for approval before being reviewed by the UM department. If you do not see the procedure listed below for which you are seeking approval, or if you are unsure if a service or procedure requires prior authorization, please contact our Utilization Management Department at 1-888-JAI-1999.

Services Requiring Prior Authorization

- Acupuncture Services for < 21 yrs.
- Ambulance/Wheelchair Van Transportation (Non-Emergent)
- Audiology devices including but not limited to hearing aids, cochlear implants, and auditory osseointegrated devices.
- Audiology device repairs (greater than $500)
- Braces and Splints (greater than $1,000 for the member's total claim)
- Cardiac Rehabilitation/Specialty Procedures
- Chiropractic Services (>10 visits) for < 21 yrs.
- Custom Foot Orthotics
- Durable Medical Equipment > $1,000.00 or rental equipment > 90 days (Including but not limited to Insulin pumps, Continuous Glucose Monitoring, Motorized Wheelchairs, Bone Growth Stimulators/Osteogenic Stimulator, Holter Monitors, External Defibrillators, Breast Pumps)
- Enteral and Parenteral Formula (< 21 years or over 21 due to medical necessity)
- Genetic Testing
- Home Health Care (>12 visits)
- Hospice (Home and Inpatient)
- Hyperbaric Oxygen Therapy
- Investigational Surgeries/Clinical Trials
- Neuro-Psychological Testing/Developmental Delay Programs
- Out-of-network services of any kind (Single case agreement must be completed)
- Outpatient Rehab- PT, OT, ST (>12 visits) for >21 yrs only
- PET Scans
- Prosthetics
- Proton Therapy Treatment
- Skilled Nursing Facility Admissions
- Sub-Acute/Inpatient Rehabilitative Services
- Sleep Studies
- Urgent Procedures or Admissions (notification to Utilization Management Department within 24-48 hours mandatory)
- Wound Vac
- Wound Clinic (>10 visits)

Procedures Requiring Prior Authorization

- Non-Urgent Inpatient Surgery
- Organ Transplants
- Bypass
- Cardiac Procedures (including, but not limited to, non-emergent cardiac catherizations, cardiac defibrillators/pacemakers, cardiac ablations)
- Amputations
- Neurosurgical procedures (including, but not limited to, **back surgeries**, craniotomies)
- Capsule Endoscopy
- Cosmetic Procedures
- Gender Transition Surgery
- Grafts/Implants
- Plastic/Reconstructive Surgery
- Corrective Surgery (including, but not limited to bunionectomies and non in office podiatric procedures)
- Neurostimulators
- Dermatology (Phototherapy, Sclerotherapy, Varicose Vein Ligation, Actinic Keratosis)

Please note: Dialysis does not require prior authorization; however a contracted facility should be used when possible. If a member requires dialysis, please notify the Utilization Management Department as soon as possible.

NOTICE:

To avoid unnecessary delays, please send elective authorizations requests at least seven (7) days before the procedure. Only written authorizations issued by JMSMCO are valid.

Please contact the Utilization Management Department at 1-888-JAI-1999 for any questions or concerns regarding prior authorizations.

Rev 8/2019

JAI MEDICAL SYSTEMS MANAGED CARE ORGANIZATION, INC.
LAB SERVICES REQUIRING PRIOR AUTHORIZATION

Jai Medical Systems Managed Care Organization, Inc. (JMSMCO) requires prior authorization for the lab services listed below. All requests must go through the PCP office for approval before being reviewed by the UM department. If you do not see the lab service listed below for which you are seeking approval, or if you are unsure if a lab service requires prior authorization, please contact our Utilization Management Department at 1-888-JAI-1999.

CPT	CATEGORY	DESCRIPTION
81202	MOLECULAR PATHOLOGY	APC GENE KNOWN FAM VARIANTS
81211	MOLECULAR PATHOLOGY	BRCA 1&2 SEQ & COM DUP/DEL
81212	MOLECULAR PATHOLOGY	BRCA 1&2 185&5385&6174 VAR
81213	MOLECULAR PATHOLOGY	BRCA 1&2 UNCOM DUP/DEL VAR
81215	MOLECULAR PATHOLOGY	BRCA 1 GENE KNOWN FAM VARIANT
81217	MOLECULAR PATHOLOGY	BRCA 2 GENE KNOWN FAM VARIANT
81220	MOLECULAR PATHOLOGY	CFTR GENE COM VARIANTS
81223	MOLECULAR PATHOLOGY	CFTR GENE FULL SEQUENCE
81226	MOLECULAR PATHOLOGY	CYP2D6 GENE COM VARIANTS
81257	MOLECULAR PATHOLOGY	HBA1/HBA2 GENE
81292	MOLECULAR PATHOLOGY	MLH1GENE FULL SEQ
81295	MOLECULAR PATHOLOGY	MSH2 GENE FULL SEQ
81298	MOLECULAR PATHOLOGY	MSH6 GENE FULL SEQ
81302	MOLECULAR PATHOLOGY	MECP2 GENE DUP/DELET VARIANT
81317	MOLECULAR PATHOLOGY	PMS2 GENE FULL SEQ ANALYSIS
81372	MOLECULAR PATHOLOGY	HLA I TYPING COMPLETE LR
81373	MOLECULAR PATHOLOGY	HLA I TYPING 1 LOCUS LR
81406	MOLECULAR PATHOLOGY	MOPATH PROCEDURE LEVEL 7
81407	MOLECULAR PATHOLOGY	MOPATH PROCEDURE LEVEL 8
81408	MOLECULAR PATHOLOGY	MOPATH PROCEDURE LEVEL 9
81415	MOLECULAR PATHOLOGY	EXOMEREVEAL PROBAND
81422	MOLECULAR PATHOLOGY	FETAL CHROMOSOMAL MICRODELETTIONS
81445	MOLECULAR PATHOLOGY	TARGETED GENOMIC SEQ ANALYSIS
81479	MOLECULAR PATHOLOGY	UNLISTED MOLECULAR PATHOLOGY PROCEDURE
87902	INFECTIOUS AGENT	HEPITITIS C VIRUS GENOTYPING
008M/S3854	MOLECULAR PATHOLOGY	PROSIGNA

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JAI MEDICAL SYSTEMS
301 INTERNATIONAL CIRCLE • HUNT VALLEY, MARYLAND 21030

STANDARD PRIOR AUTHORIZATION REQUEST FORM

Valid 90 days upon approval

Utilization Review and Case Management - Telephone: 410-433-5600 Fax: 410-433-8500

Select One: **Standard Request_____** **Urgent Request_____** **Date Request Received_____**

Member Information	
Member Name:	Date of Birth:
Member MA Number:	Member Phone Number:
Member Address:	City, State, Zip:

Requesting Provider Information	
Requesting Provider Name:	NPI:
Organization Tax ID:	Organization Name:
Address:	City, State, Zip:
Phone Number:	Fax Number:

Member Primary Care Provider (PCP) Information	
PCP Name:	NPI:
Tax ID:	Organization Name:
Address:	City, State, Zip:
Phone Number:	Fax Number:

Diagnosis	
ICD-10 Code(s) / Brief Patient History:	Description:

Procedure(s) / Service(s)	
Nutritional Supplement: yes / no (circle one) – Sole source of nutrition: yes / no (circle one)	
CPT/HCPCS Code(s):	Description:

Start Date:	Number of Visits:	Appointment Date(s):
Inpatient / Outpatient (circle one)	**If left blank, 1 assumed**	

PCP Signature_____Date_____

Enclosed: Clinical and other supporting documentation including DME form(s), if applicable

Attachment H:
Clinical Guidelines

1. Hypertension

Approximately 30% of JMSMCO's patient population is hypertensive. It is not uncommon in the JMSMCO MCO population to see patients with end-organ disease in multiple body systems. The most common organs of damage are eyes, heart, kidneys and brain. The effects of uncontrolled hypertension are devastating and irreversible, but preventable with healthy living and early detection and treatment. JMSMCO's primary care providers utilize the protocol below in order to aid in the prevention, early detection and proper management of hypertension and its known sequelae.

Based on recommendations of the JNC 7, the classification of BP (expressed in mm Hg) for adults aged 18 years or older is as follows:

Classification	**Systolic**	**Diastolic**	**Follow-up**
Normal	**<120**	**<80**	**2 years**
Pre-hypertension	**120-139**	**80-89**	**1 year**
Hypertension			
Stage 1	**140-159**	**90-99**	**2 months**
Stage 2	**≥160**	**≥100**	**Assess and treat immediately**

The classification above is based on the average of 2 or more readings taken at each of 2 or more visits after initial screening. Normal BP with respect to cardiovascular risk is less than 120/80 mm Hg. However, unusually low readings should be evaluated for clinical significance.

The natural history of essential hypertension evolves from occasional to established hypertension. After a long invariable asymptomatic period, persistent hypertension develops into complicated hypertension, in which end-organ damage to the aorta and small arteries, heart, kidneys, retina, and central nervous system is evident.

The progression of essential hypertension is as follows:

1. Prehypertension in persons aged 10-30 years (by increased cardiac output)
2. Early hypertension in persons aged 20-40 years (in which increased peripheral resistance is prominent)
3. Established hypertension in persons aged 30-50 years
4. Complicated hypertension in persons aged 40-60 years

I. Evaluation

A. Objectives:
   1. Identify known causes of hypertension
   2. Assess target organ damage and cardiovascular disease
   3. Assess response to therapy
   4. Identify cardiovascular risk factors and other diseases which may guide treatment

B. Methods:
   Clinical history should contain, at minimum, the following data:
   1. Known duration and previous B.P. readings
   2. Presence or absence of cardiac, neurologic, renal, and peripheral vascular disease, diabetes, gout, dyslipidemia by previous knowledge or by presence of specific symptoms
   3. Recent changes in weight, physical activity, sexual function, tobacco use, diet (including salt intake), alcohol consumption, fat intake, and caffeine
   4. List all prescribed and OTC medication, adverse effects, including illicit and herbal therapy
   5. Family history of hypertension, diabetes, CVA, CHD, and renal disease
   6. Social history should include education level, marital status, and employment status.

C. Complete Physical Examination:
   1. Initial lab data:
      CBC, U/A, chemistry profile, lipid profile, 12 lead E.K.G., TSH, funduscopic exam, CXR
   2. Work up for secondary hypertension if:
      a. History, physical, and initial lab data indicates
      b. B.P. responds poorly to drug treatment
      c. Previously well controlled pressure becomes uncontrolled
      d. Sudden onset of symptomatic or labile hypertension
   3. Cause of secondary hypertension
      a. Pheochromocytoma
      b. Cushing's Syndrome
      c. Primary Aldosterionism
      d. Hyperparathyroidism
      e. Renal Syndrome
      f. Sleep Apnea
      g. Substance Abuse
      h. Thyroid Disease
      i. Medications – OCPs, steroids, licorice, NSAIDS (COX-2), Epo, cyclosporine
      j. Coarctation of aorta
      k. Polycythemia vera (↑Hct)

D. Risk Evaluation:
   1. Major risk factors for development of clinical cardiovascular disease (CCD) and target organ damage (TOD)
      a. Smoking
      b. Dyslipidemia
      c. Diabetes
      d. Age over 60
      e. Menopause

f. Family history of cardiovascular disease
g. Obesity, BMI >30

2. Target organ damage
3. Heart--left ventricular hypertrophy, CAD, heart failure
4. Neurovascular- TIA, CVA
5. Renal--nephropathy
6. Peripheral vascular disease
7. Retinopathy

All patients with diabetes and one or more of TOD or CCD should receive drug therapy.

II. Drug Treatment of Hypertension

A. Treatment can be divided into:
1. Initiation
2. Individualism
3. Modification
4. Step down therapy
Please note that previously used step-up therapy is not used anymore

B. Initiation: Treatment goal is BP <140/90 mmHg. Most patients will need two medications to reach goal.
1. Lifestyle Modifications (each ↓SBP ~5mmHg)
a. Weight loss: BMI 18-24.9
b. Exercise: ≥30min/d for ≥5d/wk
c. Diet: ↑fruits & vegetables; ↓sat. and total fat (DASH Diet)
d. Na restriction ≤2.6g/d or lower

If patient does not reach BP goal then:

C. Individualism (cost factors, dosing frequency): Plasma renin profile may be helpful.
Renin low to medium – HCTZ best
Renin medium to high – ACEI (Ace inhibitors like Lisinopril) best (dlt and clonidine efficiency was independent of renin level)

III. JNC 8 Recommendations:

A. Who Should be Treated
- Patients <60 years of age: start pharmacotherapy at 140/90 mmHg.
- Patients with diabetes: start pharmacotherapy at 140/90 mmHg.
- Patients with CKD: start pharmacotherapy at 140/90 mmHg.
- Patients 60 years of age and older: start pharmacotherapy at 150/90 mmHg.

B. What is Goal Blood Pressure?
- Patients <60 years of age: <140/90 mmHg
- Patients with diabetes: <140/90 mmHg [Evidence level A]
- Patients with CKD: <140/90 mmHg
- Patients 60 years of age and older: <150/90 mmHg [Evidence level B]

C. What pharmacotherapy is recommended?
- Thiazides no longer given preference as initial therapy
- JNC 8 options for DM same as for the general population; no evidence they benefit differently from general hypertensive population
- Nonblack, including those with diabetes: thiazide, CCB, ACEI, or ARB

- African American, including those with diabetes: thiazide or CCB
- CKD: regimen should include an ACEI or ARB (including African Americans)
- Can initiate with two agents, especially if systolic >20 mmHg above goal or diastolic >10 mmHg above goal.
- If goal not reached: stress adherence to medication and lifestyle; increase dose or add a second or third agent from one of the recommended classes; choose a drug outside of the classes recommended above only if these options have been exhausted. Consider specialist referral.

D. Comorbidities (American Society of Hypertension)
   1. Diabetes:
      a. First-line: ACEI or ARB [Evidence level C; consensus] (can start with CCB or thiazide in African Americans)
      b. Second-line: add CCB or thiazide (can add ACEI or ARB in African Americans)
      c. Third-line: CCB plus ACEI or ARB plus thiazide
   2. CKD
      a. First-line: ARB or ACEI (ACEI for African Americans)
      b. Second-line (add-on): CCB or thiazide
      c. Third-line: CCB plus ACEI or ARB plus thiazide
   3. CAD:
      a. First-line: BB plus ARB or ACEI
      b. Second-line (add-on): CCB or thiazide
      c. Third-line: BB plus ARB or ACEI plus CCB plus thiazide
   4. Stroke history:
      a. First-line: ACEI or ARB
      b. Second-line: add CCB or thiazide
      c. Third-line: CCB plus ACEI or ARB plus thiazide
   5. Heart failure: ACEI or ARB plus BB plus diuretic plus aldosterone antagonist. Amlodipine can be added for additional BP control. (Start with ACEI, BB, diuretic. Can add BB even before ACEI optimized. Use diuretic to manage fluid.)

IV. Modification

A. When another disease process compels use of a specific agent

1. Type 1 diabetes with proteinuria	Ace inhibitor
2. Heart failure	Ace inhibitor + diuretic
3. Myocardial infarction	Beta blocker + ace inhibitor

V. Favorable Effect on Comorbid Condition

A. Angina	Beta blocker, CCB
B. Atrial tachycardia and fibrillation	Beta blocker, non DHP CCB
C. Cyclosporine infused hypertension	CCB
D. Diabetes both 1 & 2 with proteinuria	ACEI, CCB
E. Type 2 DM	Low dose diuretic
F. Dyslipidemia	Alpha blocker
G. Essential tremor	Beta blocker
H. CHF	ACEI/ARB, Beta blocker, Aldo antagonist
I. Migraine	Beta blocker, CCB (non DHA)

J.	Osteoporosis	Thiazide
K.	Pre-operative hypertension	Beta blocker
L.	Prostatism	Alpha blocker
M.	Post- MI	Beta Blocker, ACEI
N.	Chronic Kidney Disease	ACEI/ARB, Diuretics

VI. Unfavorable Effects

A.	Asthma	Beta blocker
B.	Depression	Beta blocker, central alpha agonist reserpine
C.	Diabetes	Beta blocker, high dose diuretic
D.	Gout	Diuretic
E.	Pregnancy	Ace, ARB

VII. Patient Education

A. Disease process and ways patients can manage their own care; Low sodium diet, weight reduction, decrease stress etc.
   1. Importance of follow-up visits; and
   2. Need for compliance with regimen to prevent unnecessary sequelae.

B. Specific dietary interventions:
   1. Soy protein may reduce both systolic and diastolic blood pressure
   2. Avoid black licorice
   3. K+ Supplementation (especially effective in African Americans)

VIII. Follow-up:

A. Provider visit every three to six months or earlier if indicated.

B. Lab Work
   1. Urine test every 12 months;
   2. EKG every 12 months;
   3. Chest X-Ray for those patients over the age of 40 with lung cancer risk factors, i.e., cigarette smoking, positive family history; and
   4. If HTN patient is taking diuretic medication, electrolytes are tested every 3-6 months or earlier as determined by the primary care provider. Potassium supplemented as necessary.

IX. Screening for Primary Hypertension in Children and Adolescents: Clinical Summary of the USPSTF Recommendation

A. Primary hypertension in children and adolescents is associated with several risk factors, the strongest of which is elevated body mass index. The prevalence of hypertension in children and adolescents has increased over the past several decades, which is probably attributable to the increase in the prevalence of childhood overweight and obesity. The prevalence of hypertension in children and adolescents in the US has been reported at 1% - 5% and among obese children in the United States, is estimated at 11%.

Population	Children and adolescents without symptoms of hypertension
Recommendation	No recommendation Grade: I statement
Risk assessment	The strongest risk factor for primary hypertension in children is elevated body mass index. Other risk factors include low birth weight, male sex, ethnicity, and a family history of hypertension.
Screening tests	Blood pressure screening with sphygmomanometry in the clinical setting may identify children and adolescents with hypertension with reasonable sensitivity; however, false-positive results may occur with normalization of subsequent blood pressure measurements.
Treatment	Stage 1 hypertension in children is treated with lifestyle and pharmacologic interventions; medications are not recommended as first-line therapy.
Balance of benefits and harms	The USPSTF found inadequate evidence on the diagnostic accuracy of screening for primary hypertension. The USPSTF also found inadequate evidence on the effectiveness of treatment and the harms of screening or treatment. Therefore, the USPSTF cannot determine the balance of benefits and harms of screening for hypertension in children and adolescents.
Other relevant USPSTF recommendations	The USPSTF has made recommendations on screening for lipid disorders in children and adolescents. These recommendations are available at http://www.uspreventiveservicestaskforce.org/.

NOTE: *For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, go to http://www.uspreventiveservicestaskforce.org/.*

USPSTF = U.S. Preventive Services Task Force.

Written by:
Hollis Seunarine, M.D., Executive Medical Director
Aye Lwin, M.D., Assistant Medical Director
Karmachandra Nair, M.D., Internal Medicine

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11. 2021 USPSTF Recommendation: Screening for Hypertension in Adults

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2. Low Back Pain

Low back pain (LBP) afflicts up to 80% of American adults during their lives. Low back pain is one of the most common complaints among JMSMCO's patients, accounting for 17.3% of the most frequent diagnoses listed in the CQI report. Back pain is the most frequent cause of activity limitation in people younger than 45 yrs, the second most common reason for patient visits, the fifth ranking reason for hospitalizations, and the third most common reason for surgical procedures. The causes of low back pain are developmental, infection, inflammatory, traumatic, metabolic, neoplastic and degenerative.

The process utilized by JMSMCO's primary care providers is as follows. A complaint of LBP is elicited during the history and risk factors are ascertained. After the appropriate musculoskeletal and neurologic examinations, medical treatment, including physical therapy if necessary, is initiated. In addition, the practitioner works with the patient to modify the home and work environment. The following is a more detailed protocol outlining this process:

A. At the initial visit, a complete history and physical exam are performed, including a neurological examination.

B. Appropriate diagnostic testing is obtained (the treating provider must evaluate the necessity of diagnostic exams , such as x-ray, before ordering) Please also see Considerations chart at the end of this guideline.
   1. CBC, blood chemistry profile, ESR, urinalysis
   2. X-rays, such as lumbar spine, lumbosacral spine
   3. MRI
   4. CT scan if MRI is contraindicated (patients with implanted pacemaker or vascular metal chips, etc.)
   5. Myelography
   6. Bone scan
   7. Electrodiagnostic studies (EMG/NCU)

C. Specific diagnosis is established.

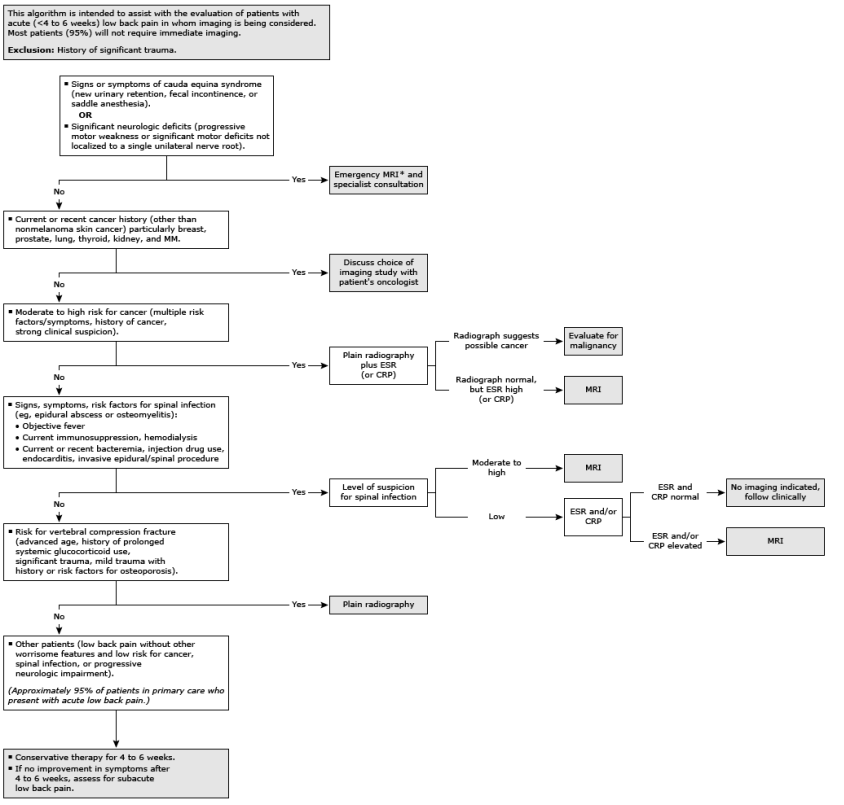
D. Treatment plan is formulated based on history, physical exam and diagnostic testing results. Typical treatment plans include treatments such as:

   1. Physical Therapy
      a. Hydroculator packs
      b. Ultrasound
      c. Electrical stimulation (TENS)
      d. Massage
      e. Therapeutic exercise
      f. Yoga

g. Spinal manipulation B chiropractic care
h. Referral to appropriate sources, as needed, such as a Neurosurgeon or an Orthopedist.

2. Medications
   a. NSAIDS, like Ibuprofen, Naproxen
   b. Muscle relaxants like Flexeril
   c. For patients who do not respond to Physical Therapy or NSAIDS, Tramadol or duloxetine can be considered, if the benefits outweigh the risks. Opioids should be for short term use only

Acute low back pain: Considerations for imaging



MRI: magnetic resonance imaging; MM: multiple myeloma; ESR: erythrocyte sedimentation rate; CRP: C-reactive protein; CT: computed tomography.
* Lumbar spine MRI without contrast is usually appropriate. If there is concern for cancer or infection or if there is history of prior surgery at the site, MRI without and with contrast is recommended. CT with contrast is the alternative exam if MRI is contraindicated.

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3. Depression/Anxiety

Approximately 25% of JMSMCO's patient population has some form of mental illness. Of this number, in a State-performed CQI report, 13.5% of these patients have some form of depression and 6% suffer from anxiety. Combined these numbers indicate that 19.5% of the medically-under served population of Maryland suffers from depression or anxiety. In response to this, the following protocol has been developed to treat depression and anxiety.

I. At the initial visit, a complete history and physical exam are performed, including laboratory evaluation and mental health screening.
   A. PHQ-2
   B. PHQ-9

II. A specific diagnosis of Depression is established using the following symptoms, in the absence of substance abuse, manic diagnosis, and/or recent death of a loved one and it must include at least 5 of the following symptoms during the same 2 week period and represent a change in previous functioning:
   A. Depressed Mood
   B. Markedly diminished interest or pleasure in activities most of the time
   C. Significant change in appetite or weight–5% change without dieting, or change in appetite.
   D. Alterations in sleep pattern (insomnia or hypersomnia)
   E. Psychomotor agitation or retardation
   F. Fatigue or loss of energy
   G. Feelings of worthlessness, excessive or inappropriate guilt
   H. Lack of concentration/ Indecisiveness
   I. Thoughts of death, dying or suicide

III. Differential includes: general medical conditions, mood incongruent delusions or hallucinations

IV. Symptoms should not be due to drug abuse, medication side effects, or general medical conditions

V. Initial Evaluations should aim to screen for other concurrent diseases and establish baseline testing
   A. Medical History
   B. Laboratory Data
      1. CBC
      2. Hemoglobin/Hematocrit
      3. Renal/Liver/Thyroid Function
      4. Electrolytes and Blood Sugar
      5. If medically indicated screen for cancer and/or infectious etiologies

VI. A treatment plan is decided upon with the patient, and initiated. Typical treatment plans include components such as:
   A. Counseling by the primary care provider

B. Consultation by psychologist or psychiatrist and/or with notification sent to ValueOptions.
C. Trial of anti-depressant medication, initiated by primary care provider
   1. Tricyclic agents (TCAs)
   2. Selective Serotonin Re-uptake Inhibitors (SSRIs)
   3. Others

D. Continual follow-up by both primary care provider and/or psychiatrists or psychologists
E. Monitor appropriate blood levels of therapeutic agents.

VII. Follow Up
A. Within the month after starting medical therapy
B. Every 4-8 weeks there after
C. Monitor appropriate blood levels of therapeutic agents

VII. Generalized Anxiety Disorder
A. Diagnosis
   1. Excessive or difficult to control worry about a number of events or activities
   2. Difficulty controlling worry
   3. Worry is associated with 3 physical symptoms that are present most of the time:
      - Restlessness or feeling on the edge
      - Easily fatigued
      - Irritability
      - Muscle tension
      - Sleep decrease
      - Decreased concentration or mind going blank

B. Symptoms cause significant distress or impairment in social occupational or other areas of functioning
C. Rule out substance abuse, medication side effect or general medical conditions
D. Treatment and Follow Up
   1. Major approaches include: cognitive –behavioral, supportive, insight oriented and pharmacotherapy
   2. Pharmacotherapy should rarely be initiated on the first visit
      May include Benzodiazepines, Buspirone, Venlafaxine, SSRI's

E. Patients may call SAMHSA's National Helpline at 1-800-662-HELP (4357)

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Emily Sippel, M.D.
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4. High Risk for HIV Infection Protocol

I. The Centers for Disease Control (CDC) recommends HIV screening for ages 13-64. USPSTF recommends HIV screening for ages 15-65, younger/older if high risk, and all pregnant women (Grade A). Everyone should be tested at least once in their lifetime.

A. Obtain informed consent for:
   1. Antigen/Antibody test (detect HIV 15-45 days post exposure)
   2. Rapid Antigen/Antibody test (18-90) from a finger prick
   3. Antibody test-blood or oral fluid (23-90 days post Exposure)
   4. NATs-detects actual virus in blood. (10-33 days after exposed) PCR is one type of NATs) It is a very expensive test.
   5. RNA PCR-useful if acute infection suspected

   *If the first test is a rapid test or a self-test and is positive, this should be confirmed with a lab test.

B. Rapid preliminary tests: Ag/Ab by finger prick or Ab test by finger prick or oral fluid (requires confirmation)
   1. A positive rapid test should be confirmed with a Lab test:
      a. Ag/Ab combo – detects hiv 1 & hiv 2 antibody and hiv p24 antigen
      b. Hiv 1,hiv 2 antibody differentiation immunoassay
      c. Hiv 1 NAT – hiv nucleic acid amplification test

C. If testing negative after potential exposure, retest 3 months after exposure
   1. Everyone between the ages of 13-64 should be tested once.

D. High risk- at least once a year.

E. Type of tests:
   A. HIV test in the lab
      - HIV-1/2 Ag/Ab Combo immunoassay

      If 1 reactive:
      - HIV-1/HIV-2 antibody differentiation immunoassay

      If non-reactive or intermediate
      - HIV-RNA assay

   B. Rapid tests- if positive need to be repeated in the lab with test A.
   C. If testing negative after potential exposure

II. At the initial patient visit, perform

A. Complete history and physical examination.
A. Medication review
B. History or evidence of opportunistic infections, malignancy, STIs

III. Patient education is focused on safer sex practices, proper condom use, proper needle handling and disposal, regional needle exchange programs, and substance abuse treatment, as needed.

IV. PEP (Post-Exposure Prophylaxis)

PEP is the use of antiretroviral drugs after a single high-risk exposure event to stop hiv seroconversion.

Start the meds ASAP and always within 72 hours of possible exposure.

A. If significant exposure, initiate ≥3 drug regimen ASAP (within 72 hours to be effective), for 4 weeks.
B. Preferred Regimes:
   a. Truvada (tenofovir/emtricitabine) once a day with Raltegravir 400 mg twice a day for 4 weeks. This regime can be used for anyone.
   b. Truvada (tenofovir/emtricitabine) once a day with Dolutegravir 50 mg once a day for 4 weeks.

   This regime cannot be used in pregnant females or females of childbearing age not on contraception.

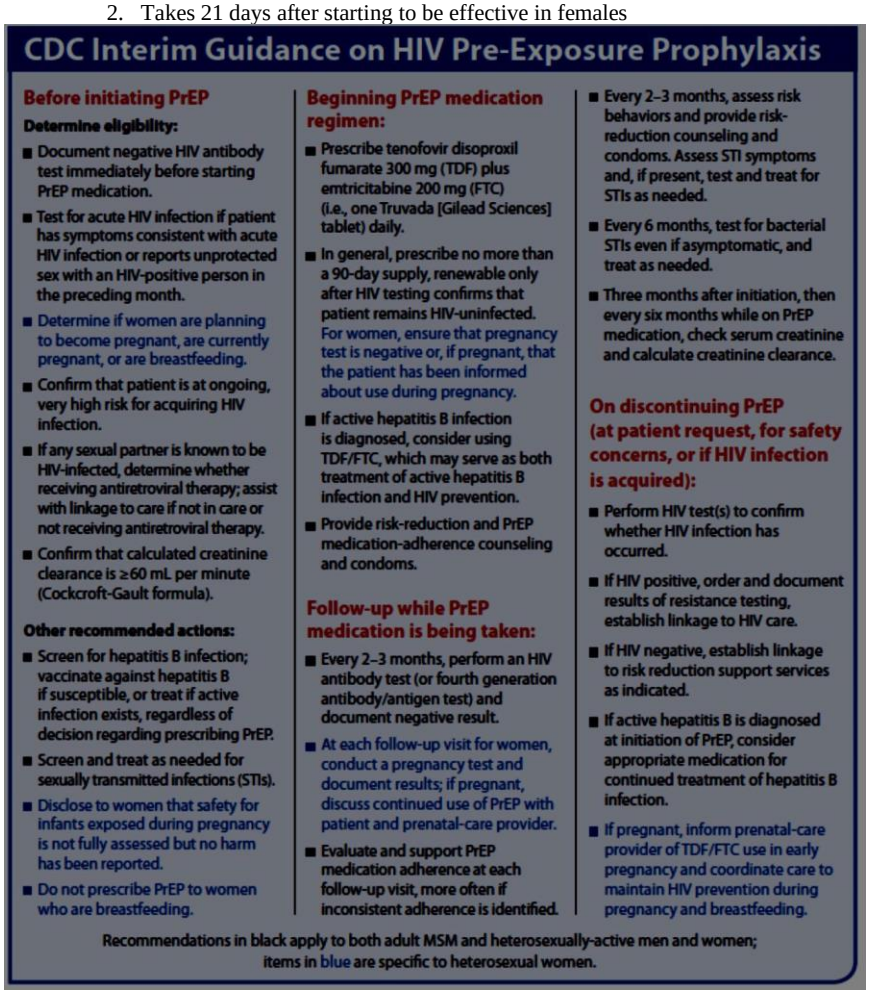
C. Can use same treatment for occupational and nonoccupational exposures.
D. Consider expert consultation, but do not delay treatment
E. Recommended follow-up:
   1. HIV testing at baseline and at 6 weeks, 12 weeks, and 6 months after exposure. Alternatively, if the clinician is certain that a fourth-generation combination HIV p24 antigen–HIV antibody test is being utilized, then HIV testing could be concluded at 4 months after exposure.
   2. Complete blood counts, renal, and hepatic function tests (at baseline and 2 weeks after exposure; further testing may be indicated if abnormalities are detected).
   3. Additional testing recommended for non-occupational exposures, where there is concern for other transmissible diseases (see referenced guideline #7).
   4. If the patient tested negative after a potential exposure, retest after 3 months.
F. National Clinicians' Post-Exposure Prophylaxis Hotline at telephone number 888-448-4911 and website http://www.nccc.ucsf.edu/about_nccc/pepline/

V. PrEP (Pre-Exposure Prophylaxis)
A. Only in those with very high risk of contracting HIV through sex or injection drug use. CDC recommends daily regime.
B. Truvada (tenofovir/emtricitabine) is FDA approved for PrEP among adults at risk for HIV infection.
C. Descovy (except receptive vaginal sen) due to there being no studies done.
C. Eligibility criteria: Negative test for HIV, CrCl must be >60, persistent/ongoing risk.
   1. Provide a 90-day supply of medications
D. Monitoring:
   1. Q 3 months with HIV testing, reassessing risk, counseling on risk reduction.
   2. Screen for other STI's Q6 months
   3. Monitor BUN/Cr Q 3months for first year, annually thereafter
   4. Check b-HCG in women of reproductive age before and Q 3 during tx.

E. PrEP Hotline: PrEPline, 1-855-448-7737 (1-855 HIV-PREP)

VI. Time to protection:

1. Takes 7 days after starting to be effective in males
2. Takes 21 days after starting to be effective in females



CDC Interim Guidance on HIV Pre-Exposure Prophylaxis

Before initiating PrEP

Determine eligibility:

- Document negative HIV antibody test immediately before starting PrEP medication.
- Test for acute HIV infection if patient has symptoms consistent with acute HIV infection or reports unprotected sex with an HIV-positive person in the preceding month.
- Determine if women are planning to become pregnant, are currently pregnant, or are breastfeeding.
- Confirm that patient is at ongoing, very high risk for acquiring HIV infection.
- If any sexual partner is known to be HIV-infected, determine whether receiving antiretroviral therapy; assist with linkage to care if not in care or not receiving antiretroviral therapy.
- Confirm that calculated creatinine clearance is ≥60 mL per minute (Cockcroft-Gault formula).

Other recommended actions:

- Screen for hepatitis B infection; vaccinate against hepatitis B if susceptible, or treat if active infection exists, regardless of decision regarding prescribing PrEP.
- Screen and treat as needed for sexually transmitted infections (STIs).
- Disclose to women that safety for infants exposed during pregnancy is not fully assessed but no harm has been reported.
- Do not prescribe PrEP to women who are breastfeeding.

Beginning PrEP medication regimen:

- Prescribe tenofovir disoproxil fumarate 300 mg (TDF) plus emtricitabine 200 mg (FTC) (i.e., one Truvada [Gilead Sciences] tablet) daily.
- In general, prescribe no more than a 90-day supply, renewable only after HIV testing confirms that patient remains HIV-uninfected. For women, ensure that pregnancy test is negative or, if pregnant, that the patient has been informed about use during pregnancy.
- If active hepatitis B infection is diagnosed, consider using TDF/FTC, which may serve as both treatment of active hepatitis B infection and HIV prevention.
- Provide risk-reduction and PrEP medication-adherence counseling and condoms.

Follow-up while PrEP medication is being taken:

- Every 2–3 months, perform an HIV antibody test (or fourth generation antibody/antigen test) and document negative result.
- At each follow-up visit for women, conduct a pregnancy test and document results; if pregnant, discuss continued use of PrEP with patient and prenatal-care provider.
- Evaluate and support PrEP medication adherence at each follow-up visit, more often if inconsistent adherence is identified.
- Every 2–3 months, assess risk behaviors and provide risk-reduction counseling and condoms. Assess STI symptoms and, if present, test and treat for STIs as needed.
- Every 6 months, test for bacterial STIs even if asymptomatic, and treat as needed.
- Three months after initiation, then every six months while on PrEP medication, check serum creatinine and calculate creatinine clearance.

On discontinuing PrEP (at patient request, for safety concerns, or if HIV infection is acquired):

- Perform HIV test(s) to confirm whether HIV infection has occurred.
- If HIV positive, order and document results of resistance testing, establish linkage to HIV care.
- If HIV negative, establish linkage to risk reduction support services as indicated.
- If active hepatitis B is diagnosed at initiation of PrEP, consider appropriate medication for continued treatment of hepatitis B infection.
- If pregnant, inform prenatal-care provider of TDF/FTC use in early pregnancy and coordinate care to maintain HIV prevention during pregnancy and breastfeeding.

Recommendations in black apply to both adult MSM and heterosexually-active men and women; items in blue are specific to heterosexual women.

http://www.cdc.gov/hiv/prep/pdf/PrEPfactsheet.pdf

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Sources:

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5. Women's Health Protocol

I. At the initial visit, a complete history including menstrual and reproductive health and physical exam are performed.

A. It is recommended that women receive at least one preventive visit per year beginning in adolescence and continuing across the lifespan, including preconception services and prenatal care.

B. Patients should be counseled that annual well woman visits are recommended even if cervical cancer screening is not performed each year.

C. It is an opportunity to discuss other health problems and preventive measures.

II. The components of the annual women's health preventative services:
A. Blood pressure, weight check and body mass index
B. Screening for gestational diabetes is conducted between 24-28 weeks of gestation or sooner in women with high risk factors for pre-existing diabetes. Screening for diabetes after pregnancy is done within the first year postpartum (may be done as early as 4-6 weeks postpartum). Rescreen every 3 years for a minimum of 10 years.
C. Breast exam
D. Screening for cervical cancer: Women age 21-29 years = cervical cytology (Pap) every 3 years without HPV co-testing. Women age 30-65 years = cervical cytology every 3 years or co-testing with cytology and HPV every 5 years.
E. Colon Cancer screening beginning at age 50 or earlier depending on risk
F. Tobacco, alcohol, and drug use screening and counseling
G. Dietary/ nutrition, and physical activity assessment
H. Sexual practices

III. The health care provider will review patients' contraceptive methods and ensure patients' satisfaction with their method of choice. The importance of practicing safe sex at every encounter should be stressed. The most used types of contraceptive methods are:
A. Oral contraceptive pill
B. Depo-Provera
C. Nura Ring
D. Transdermal Patch
E. Condoms
F. IUD
G. Implantable contraception
H. Tubal Ligation
Other Contraceptive Methods:
Diaphragm, contraceptive sponge, spermicides and emergency contraception (Plan-B)

IV. If the patient desires to become pregnant, preconception counseling should emphasize the importance of early prenatal care, proper diet, use of vitamins and folic acid, and avoidance of alcohol, tobacco, and other drugs. Patients should be advised to avoid travel to places with active Zika virus transmission. Comprehensive lactation support services including counseling

and education needed during antenatal and postpartum period to ensure successful initiation and maintenance of breastfeeding.

V. Monthly self-breast exams should be reinforced, and correct techniques reviewed. A clinical breast exam should be performed yearly.

VI. Women should receive regular mammogram screening appropriate for their age group and risk profile. Breast Cancer screening with mammogram for average risk women should start no earlier than age 40 and no later than age 50 with intervals of 1-2 years and should continue through at least age 74.

VII. Women should receive bone mineral density screening with DXA at age 65. High risk women should have the screening earlier.

VIII. Women who are menopausal should be counseled regarding latest recommendations regarding hormone replacement therapy and their options for symptom management. Treatment should be based on the delicate balance between benefit versus risk.

IX. The patient should be counseled regarding diet and nutrition and incorporating regular physical activity into daily routines. The importance of exercise at every age should be stressed and the significance of a balanced diet with calcium supplementation at an early age in the prevention of osteoporosis should be reviewed. A low fat and reduced carbohydrate diet should be reinforced, and the risks of obesity discussed.

X. Women with high risk factors should be screened for substance abuse and receive appropriate counseling and rehabilitation.

XI. High risk reduction education and STD including HIV testing should be offered to sexually active individuals.
   A. Counseling for STD: Sexual history and risk factors help identify those with increased risk of STI's including age younger than 25, recent history of STI, new sex partner, multiple partners, partner with concurrent partners, partner with STI and inconsistent condom use.
   B. Screening for HIV: Education and risk assessments should be done annually from adolescence throughout the lifespan. All women should be test at least once during their lifetime. More frequent screening may be needed for those at high risk.

XII. A safety assessment to screen for domestic violence and a mental health assessment to screen for depression and other disorders should be performed regularly.

   A. Interpersonal and domestic violence: Screen adolescents and women for physical violence, sexual violence, stalking, psychological aggression, reproductive coercion, neglect and threat of violence and/or abuse.
   B. Assessment for anxiety and other mental health disorders should be performed.
   C. Interventions include counseling, education, harm reduction strategies and referral to appropriate supportive services.

XIII. The need for immunizations should be evaluated including:

A. Td booster every 10 years; administer a dose of Tdap if not previously received; Tdap is recommended with each pregnancy
B. Influenza vaccine annually
C. Pneumococcal vaccine for the elderly/high risk individuals
D. Hepatitis B vaccines in high risk persons
E. Varicella vaccines in susceptible individuals
F. HPV vaccines between 9 and 26 years of age
G. Herpes Zoster vaccine at age 60 or older.
F. Meningococcal vaccine in high risk individuals

XIV. Screening for Urinary Incontinence: This should be conducted annually and if present, ask whether this impacts their activities and quality of life. Risk factors include increasing parity, advancing age and obesity.

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6. Children with Special Health Care Needs

Children with special health care needs are children who are at increased risk of developing a chronic physical, developmental, behavioral, or emotional condition and require services beyond that usually required by children. The prevalence of children with disabilities has increased in the United States in recent years.

I. Complete history and physical on initial visit with particular emphasis on:

A. Prenatal exposures including medications and drugs
B. Prenatal infections
C. Family history
D. Prior pregnancy history
E. Child's medical history and neurodevelopmental status including a history of prematurity, head injury, or chromosomal disorders (e.g. Down's Syndrome, Fragile X, Tuberous Sclerosis)
F. Features of genetic syndromes (e.g.: Brushfield spots, webbed neck, coarse facial features, hepatosplenomegaly, dysmorphic features, macro or microcephaly)
G. Neurological findings (e.g.: cranial nerve function, hyper/hypotonicity)
H. Developmental screening assessments if applicable (e.g. the Modified Checklist for Autism in Toddlers (MCHAT) at 18 and 24 months and the Ages and Stages Questionnaire (ASQ) at 9, 18 and 24 months.)

II. Laboratory and Diagnostic studies as indicated:

A. Blood and/or urine tests
   1. Chromosome microarray
   2. Fluorescent in situ hybridization
   3. Screening for inborn errors of metabolism e.g. urine for amino and organic acids, plasma for amino acids and acylcarnitines
B. MRI
C. X-rays, EKG, EEG

III. Establish a diagnosis(es) based on above information. Refer to genetic, neurology, cardiology, developmental specialists, audiology and ophthalmology, if indicated.

IV. Develop a comprehensive chronic condition management plan. Care should focus on maximizing health and wellness, and promote quality of life and optimal development. Administer medical treatment in accordance to the plan. Refine the treatment plan regarding symptom management and surveillance for known complications. Refer the patient to case management, using a JMS referral form. If the patient qualifies, please enroll in REM.

V. Refer for early intervention and necessary therapies such as speech, occupational, applied behavioral analysis, physical, and behavioral therapies as soon as possible.

VI. Establish a medical home to include the provision of culturally effective, coordinated, and comprehensive care for the child. Ensure the best health and social services for the child and family. Integrate care with other providers and encourage the family to share in decision making. Care should be patient and family centered. Medical staff should engage families as partners and allow them to participate in the child's health care and goal planning.

VII. Address the child's needs for appropriate individualized educational services and access to adequate community services. Screen for comorbid conditions such as ADHD, anxiety and mood disorders and refer as needed to mental health/ behavioral specialists. Coordinate care with mental health and behavioral health professionals, and the educational system. Refer for condition-specific family support.

VIII. Provide reasonable access to routine and urgent medical, oral and mental health.

IX. Review care plan at least annually.

X. Assure accessibility to necessary durable medical equipment and supplies and home health services.

Written by:
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7. Individuals with a Physical Disability

I. Principles and Goals

A. Comprehensive effort that incorporates physical, emotional and social parameters in the process of care.
B. Team effort that is multi-disciplinary in membership and interdisciplinary in process.
C. Not to be a limited intervention.
D. Frequently involving a plan of care that is continuing and intended for long-term follow-up.
E. Primarily focused on functional abilities of patient

1. Function that has been lost and may be restored.
2. Remaining function that needs to be protected and strengthened to accommodate disabilities resulting from lost functions unable to be restored.

II. Complete History and Physical Exam on initial visit to differentiate

A. Acquired causes of disability (e.g.: stroke, cancer, trauma, etc.).
B. Congenital causes of disability (e.g.: club feet, shortened or missing limb, birth trauma, etc.).

III. Diagnostic studies

A. Blood work profiles
B. Mini Mental Status
C. Radiology

1. X-rays
2. CT Scan
3. MRI
4. EMG

D. Nerve Conduction Studies
E. Vascular Studies
F. Other special labs or tests particular to the disability

IV. Assess Activity Capacity

A. Assess Functional Residual Capacity
B. Assess ability to perform Activities of Daily Living (ADLs) (e.g.: brush teeth, use toilet independently, dress self, bathe)
C. Assess ability to perform Instrumental Activities of Daily Living (e.g.: make a phone call, write a check, access transportation)
D. Collaborate with Home Health Agency, as needed.

V. Assess for Mental Illness secondary to physical disability.

VI. Treat Symptoms or Underlying Condition, if able

A. Medication

1. NSAID's
2. Narcotics
3. Muscle relaxants
4. Blood thinning agents
5. Bone-building agents
6. Other, as needed

B. Referral to specialty services, as needed

VII. Acquire Durable Medical Supplies, as needed

A. Assistive devices (e.g.: canes, walkers, crutches, shower stools, orthotics)
B. Home monitoring equipment (e.g.: glucometers)
C. Supportive devices (e.g.: braces, splints)
D. Personal needs equipment (e.g.: colostomy care products)

VIII. Ensure transportation to and from PCPs office.

IX. Assess patient's housing situation.

A. Work with Housing Authority to obtain necessary requirements, such as:

1. Ground floor
2. Elevator
3. Handicapped parking
4. No carpet
5. Well-lit hallways
6. Stall shower.

B. Advise patient to maximize available properties of current home and ensure safety factors:

1. Clear pathways through home
2. Wear slippers
3. Remove throw rugs, etc.

X. Facilitate changing insurance plans, as needed, according to disability level and permanence

A. Attempt to return patient to work force
B. Social service referral if potentially out of work for extended time
C. Perform disability determinations.

XI. Perform long-term monitoring and follow-up care

XII. Evaluate for intermediate or long-term care facility.

Written by:
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Aye Lwin, M.D., Assistant Medical Director
Sources:
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8. Individuals with a Developmental Disability

I. Definition of Developmental Disability:

Group of chronic, non-progressive neurologic disorders with an onset from prenatal period through childhood and which continues into adulthood

II. Complete history and physical should be performed on the initial visit with particular emphasis on:

A. Family/Genetic history
B. Pregnancy history including exposures, toxins, drugs, and infections
C. Perinatal history
D. Developmental history
E. Educational history including adaptive, communication, and self care functioning
F. Social history
G. Complete Neurological Exam

III. Laboratory tests are indicated by the findings and history and may include:
A. Chromosomal analysis
B. Appropriate test for inborn errors of metabolism
C. Brain imaging studies (MRI)

IV. The comprehensive assessment also includes standardized intelligence and psycho-educational testing. Prior assessment results should be reviewed and additional testing requested when indicated.

V. Establish a diagnosis based on the above information:

A. Intellectual Disability
B. Motor skills disorders
C. Speech disorders
D. Learning disorders
E. Mood disorders
F. Autism spectrum disorders
G. ADHD and disruptive behavior disorders
H. Medical/neurological primary diagnoses, e.g., fetal alcohol syndrome, fragile X syndrome

VI. An Individualized Care Plan (ICP) should be developed and the patient should be referred to case management.

VII. The management of persons with developmental disabilities is typically multidisciplinary. Early intervention should be instituted including educational and ancillary therapies such as physical, occupational, language, and family support.

VIII. Medical and psychological treatment should be administered in accordance with ICP goals. Referrals to specialists based on those goals should be done using approved network providers whenever possible.

IX. A medical home should be established to coordinate and remove barriers to adequate health care.

X. The patient should have access to medically necessary equipment

XI. The patient's progress should be monitored and the ICP should be reviewed/updated at lest annually to address any changes in the patient's health needs.

XI. The medical needs of the whole person, not just the disability should be addressed. A healthy lifestyle should be promoted including proper nutrition and physical activity as tolerated. Age appropriate clinical preventive services should be recommended. Ensure the patient has the opportunity to participate in every aspect of life to the best of their abilities.

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Sources:

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9. Pregnant & Postpartum Women

(It is important that all pregnant women are seen for prenatal care as early as possible during their pregnancy, preferably during the first trimester of pregnancy or within 42 days of enrollment with Jai Medical Systems Managed Care Organization, Inc. – per HEDIS quality assurance standards.)

Note: For PCPs who see a patient for initial diagnosis or confirmation of pregnancy, but will not be providing subsequent global OB care, the Jai MCO's requirements for the visit include:

A. E/M code 99201-99205 or 99211-99215 as appropriate
B. Order an obstetric prenatal lab panel
C. Document LMP or EDD and obstetric history
D. Document counseling and education
E. Diagnosis of pregnancy coded on bill
F. Refer patient to OB case management, using appropriate form

Note: Though not a listed requirement, Rx of a prenatal vitamin is also appropriate.

Note II: Given that nearly half of pregnancies are unintended, preconception counseling/care should be considered an integral part of primary care for women of reproductive age. It is important to assess for:

A. Environmental exposures (toxicants at work and in the home)
B. Family genetic history
C. Substance Use
D. Medications
E. Nutritional considerations
F. Psychiatric Illness
G. Infectious Diseases
H. Overweight / Underweight / history of Bariatric surgery

I. Identification & Health History of Patient

A. Confirm Pregnancy
   1. Physical Exam
   2. Urine
   3. Blood

B. Complete the Maryland Prenatal Risk Assessment Form

C. History of patient, with focus on:
   1. Presenting pregnancy
   a. Calculate Estimated Date of Confinement (EDC)
      i. Nägele's Rule, based on LMP
      ii. Uterine size by palpation as well as in centimeters

- at 8wks, pubic symphysis
- at 12wks, slightly above pubic symphysis
- at 15wks, midway between pubic symphysis and umbilicus
- at 20wks, umbilicus

b. Common signs & symptoms of pregnancy patient is currently experiencing
c. Care to date
    i. Begun vitamins?
    ii. Adjusted eating habits to pregnancy requirements?

D. Previous pregnancy history, if any
1. Length of gestation
2. Birth weight
3. Fetal outcome
4. Length of labor
5. Fetal presentation
6. Type of delivery
7. Complications

E. Medical history, with focus on:
1. Chronic diseases, such as:
    a. Hypertension
    b. Diabetes
    c. Sickle Cell Trait/Anemia
    d. Hepatitis (all types)
    e. HIV
    f. Thyroid Dysfunction
    g. Tuberculosis
2. Drug allergies
3. History of blood transfusions
4. History of cancer
5. History of sexually transmitted diseases (STD)
6. Potential risk of current STD
7. History of (or current) Substance Abuse
8. Current mental illness
9. Travel history

F. Surgical history, with focus on:
1. GYN surgery
2. Induced abortions
3. Previous Caesarean delivery and reason

G. Family history, with focus on:
1. Diabetes, gestational or otherwise
2. Pregnancy difficulties, including large babies
3. Hypertension, during pregnancy or otherwise
4. Stillbirths

5. Multiple pregnancy
6. Cancer
7. Other inheritable diseases

II. Physical Exam

A. Complete physical exam, head to toe, including vital signs

B. Complete pelvic exam
   1. Pap smear – only if due to be done by standard screening guidelines.
   2. Cervical cultures for STDs (at initial exam and at 36th week)
      a. Gonorrhea
      b. Chlamydia
      c. β-Strep (35-37 weeks only)
      d. Others
   3. Examination of pelvic soft tissue for masses or other unusual qualities
   4. Examination of the bony pelvis

C. TB skin test – if otherwise indicated

III. Lab Work

A. Basic blood screening
   1. Complete blood count with differentiation
   2. Blood group type
   3. Rh factor
   4. Blood group antigen antibodies (at initial exam and at 28wks if unsensitized Rh neg.)
   5. RPR (at initial exam and 28 wks)
   6. Rubella titer
   7. Varicella titer
   8. Hepatitis diagnostic profile
   9. HIV (with pre- and post-test counseling)

B. Urine screening (UA with microscopic & culture) to look for:
   1. Infection
   2. Protein
   3. Glucose

C. Pregnancy specific screening
   1. Sonogram:
      - To improve dating accuracy if uncertain LMP
      - Anatomy scan at 18-22wk
      - For other concerns
   2. Aneuploidy screen 1st and/or 2nd trimester labs +/-US
   3. Neural tube defect screen - Maternal serum AFP +/- US @15-20wks
   4. Chorionic villus sampling (CVS) – if indicated, after 10wks
   5. Amniocentesis (if indicated) - done at 16wks
   6. Glucose tolerance test - done at 26-28wks

7. Group β-strep culture of lower vagina - done between 35-37wks
8. Zika testing if appropriate

D. Immunizations
1. Rh vaccine – if Rh negative, Rh immune globulin done at 28 wks,w/in 72 hr of delivery, and whenever there is risk of fetomaternal hemorrhage
2. Influenza vaccine (inactivated) recommended
3. Tdap – done at 27-36wk of each pregnancy

IV. General Prenatal Care Concepts for healthy, singleton pregnancy

A. Ideal frequency of visits
1. Initial exam - up to 30 wks gestation - visit every four weeks
2. 30 wks - 36 wks gestation - visit every two weeks
3. 36 wks - delivery - every week

B. Details to note at each exam:
1. Maternal weight gain or loss
2. Maternal blood pressure
3. Fundal height
4. Abdominal exam findings
5. Normal fetal heart tones
6. Maternal urine
7. Protein
8. Glucose
9. Screen for depression and domestic violence
10. Screen for ongoing substance abuse

C. Encourage mother to enroll and participate in educational programs
1. Newborn care
2. Childbirth experience
3. Nutrition during pregnancy

D. Recommend:
1. Multivitamin supplementation
2. Preventative dental services
3. Regular mild to moderate exercise
4. Appropriate weight gain per IOM 2009 guidelines, by pre-pregnancy BMI
   - BMI <18.5 kg/m^2 (underweight) — weight gain 28 to 40 lbs (12.5 to 18.0 kg)
   - BMI 18.5 to 24.9 kg/m^2 (normal weight) — weight gain 25 to 35 lbs (11.5 to 16.0 kg)
   - BMI 25.0 to 29.9 kg/m^2 (overweight) — weight gain 15 to 25 lbs (7.0 to 11.5 kg)
   - BMI ≥30.0 kg/m^2 (obese) — weight gain 11 to 20 lbs (5 to 9.0 kg)

4. No travel to areas with Zika. Steps to prevent mosquito bites and transmission of Zika virus through sex should be discussed

E. Send copy of prenatal records to hospital at 34-36 wks, in preparation for labor and delivery; weekly copies after

V. Some Common Complaints & Their Treatments (if any)

A. Urinary frequency
   1. No treatment if urine is negative.
   2. Asymptomatic bacteria should be treated, due to risk of pyelonephritis

B. Back and/or pelvis pain
   1. Wear maternity girdle
   2. Rest frequently
   3. Local heat and back/message rubs

C. Varicose Veins
   1. Elastic stockings
   2. Elevation of legs
   3. Frequent rest
   4. Monitor for signs & symptoms of deep vein thrombosis

D. Lower limb edema
   Elevate legs

E. Breast Tenderness
   1. Wear good-fitting bra 24hrs/day
   2. Decrease caffeine products

F. Nausea & Vomiting
   1. Small frequent meals, solids and liquids separately
   2. Decrease caffeine products
   3. Anti-histamines
   4. Vitamin B_6

G. Sexually transmitted diseases
   1. Syphilis
      a. Penicillin
      b. Erythromycin
      c. Ceftriaxone (Category B)
   2. Chlamydia
      a. Zithromax (Category B)
      b. Erythromycin
   3. Gonorrhea

Ceftriaxone

4. Herpes Simplex
   a. Acyclovir prophylaxis from 36wk if symptomatic during pregnancy
   b. Cesarean delivery, if active when in labor

H. Other vaginal irritations
   1. Trichomoniasis
      a. Oral Flagyl (only after 1st trimester) (Category C)
      b. Vaginal Metrogel (any time)
      c. Clindamycin, vaginally
   2. Candidiasis
      a. Terazol (2nd and 3rd trimesters only) (Category C)
      b. Monistat (Category C)
      c. Mycostatin
      d. Topical Imidazole

I. GERD
   Antacids

J. Constipation/Hemorrhoids
   Dietary modifications including more bran and wheat

VI. Signs of Potential Problem
   A. Upper extremity and/or facial edema
   B. Unexplained Bleeding
   C. Unexplained elevated AFP levels
   D. Low maternal weight gain (in a non-obese patient) or excessive weight gain.
   E. Decrease or cessation of fetal movement
   F. No evidence of maternal blood pressure drop with increasing gestation
   G. Compounding maternal medical problems
   H. Substance use/abuse
   I. Nicotine dependence
   J. Preterm uterine cramping with severe pain
   K. Abnormal fetal growth
   L. Vaginal infection
   M. Exposure to fetotoxic agents
      1. Irradiation
      2. Viruses
      3. Gases
      4. Drugs

VII. Basic Principles of High Risk OB Management
   A. Frequency of visits
      Increase frequency as indicated throughout pregnancy to allow for close monitoring

   B. Additional Testing (as indicated)

1. Ultrasound
2. Amniocentesis
3. Chorionic Villus sampling
4. Fetal Blood Sampling
5. Maternal Alfa-Fetoprotein testing
6. Maternal and Paternal Karyotyping
7. Pulmonary Maturity testing
8. Zika testing if traveled to a high risk area

C. Biometric Evaluations of Fetal Well-being - done at appropriate intervals
1. Fetal Movement Counting
2. Doppler Ultrasound
3. Nonstress Testing
4. Contraction Stress Testing
5. Biophysical Profile

D. Management of specific concurrent maternal diseases according to recent research-based protocols

VIII. Postpartum Care
A. In-hospital Care
1. Rubella vaccine (if needed)
2. Varicella vaccine (if needed)
3. Rh immune globulin (if needed)
4. TdaP vaccine (if not done during pregnancy)
5. Monitor bladder function, secondary to birth trauma
6. Monitory bowl function, secondary to birth trauma
7. Ensure general good hygiene, particularly of the perineal area
8. Monitor lochia drainage
9. Ambulate to prevent deep vein thrombosis
10. Ensure adequate nutrition
11. Discuss contraception
12. Discuss breastfeeding

B. At-home care
1. First month
a. Monitor for fever, pain, heavy bleeding, or excessive breast tenderness - call doctor immediately if experiencing these
b. Rest
c. Restrict activity level for first three weeks

2. Consider contraceptive options

3. Schedule more than one postpartum exam appointment between two and eight weeks (14-56 days after delivery to meet HEDIS guidelines), consider additional

visit if cesarean delivery, medical issues require follow-up, or at risk for post-partum depression.

a. Maternal and newborn's weight
b. Maternal blood pressure
c. Maternal CBC with differentiation if indicated
d. Breast exam
e. Pelvic exam with rectal exam
f. Episiotomy (and any other reparative sutures) examination
g. Discuss contraception/family planning
h. Ensure adequate newborn nutrition/breastfeeding issues
i. Discuss any areas of concern to patient
j. Assess maternal ability to return to work
k. Discuss safe infant sleep patterns
l. Screen for diabetes in individuals with previous gestational diabetes
m. Screen for postpartum depression
n. HEDIS requirements
    - Code for postpartum visit as appropriate
    - Document at least one of the following:
        - A pelvic exam
        - Evaluation of weight, breasts, abdomen, and BP
        - A notation of postpartum care

4. Manage other postpartum problems i.e. pelvic floor exercises for stress urinary incontinence and water-based lubricants for dyspareunia.

5. Screen for tobacco use and counsel regarding relapse risk in postpartum period.

6. Screen for substance use disorder and refer as indicated.

7. Guidance regarding return to fertility while lactating.

8. Provide guidance regarding sexuality and resumption of intercourse.

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Sources:

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8. *ACOG Committee Opinion of Immediate Postpartum Long-Acting Reversible Contraception Recommendations, Aug 2016*
9. Optimizing Postpartum Care – ACOG Committee Opinion, May 2018

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10. Individuals who are Homeless

I. Principles & Goals
- A. Multi-disciplinary team approach to address the unique needs of the homeless patient, particularly:
  1. Physical illness
  2. Emotional illness
  3. Substance Abuse problems
  4. Nutritional problems
  5. Lack of:
     a. Stable housing arrangements
     b. Employment
     c. Income
     d. Health insurance
     e. Health care access
- B. Identify that they are four times more likely to die than age-matched controls

II. Complete Psychosocial Evaluation
- A. Psychosocial History Assessment
  1. Educational achievements
  2. Job/employment/armed forces history
  3. Housing history
  4. Substance abuse history & evaluation
  5. Family history
  6. Domestic violence
  7. History of survival sex
- B. Comprehensive Mental Health Assessment
  1. Mental status exam
  2. Previously diagnosed mental disorders
  3. Symptomatology
  4. Personality & Coping Assessment
  5. Medication history
- C. Lifestyle-related Disease Assessment
  1. Substance abuse
  2. Alcohol abuse
  3. Nicotine abuse
  4. Birth control evaluation
  5. Communicable diseases

III. Complete History & Physical Examination
- A. Comprehensive Medical History
- B. Hospitalizations
- C. Review of Current Symptoms

D. Comprehensive physical exam, with additional emphasis on:
    1. Skin integrity
    2. Oral mucosa integrity/teeth health
    3. Vision capabilities
    4. Hearing capabilities
    5. Foot examination

IV. Diagnostic Studies
A. Basic lab work
    1. Complete blood count
    2. Urinalysis & urine drug screen
    3. Automated chemistry panel
    4. Hepatitis Diagnostic Profile
    5. Prostate Specific Antigen (PSA), if indicated
B. Radiological studies
C. Tuberculosis screening
D. STD screening
E. HIV testing (with pre- & post-test counseling)
F. Immunization Assessment
    1. Influenza
    2. Tetanus
    3. Pneumococcal
    4. Hepatitis B, if indicated
G. Comprehensive GYN exam
H. Mammography, if indicated
I. Other tests, as needed & indicated

V. Treatment of Physical Problem
A. Medications appropriate to diagnoses established
B. Referral to specialty services
    1. Psychiatry
    2. Orthopedic
    3. Podiatry
    4. Dental
    5. Others

VI. Treatment of Emotional Problems
A. Medications appropriate to diagnoses established
B. Referral to In-house Mental Health Department
C. Referral to Adult Day Care
D. Referral to hospital, if indicated as necessary

VII. Treatment of Psychosocial Problems
A. Referral to appropriate social agencies
    1. Housing Authority
    2. Department of Social Services
    3. Department of Education’s Homeless Coordinator

B. Referral to Case-Management Social Work agencies
C. Referral to Substance Abuse Treatment programs
    1. Through primary care provider
    2. Through In-house Mental Health Department
    3. Through outside In-patient services

VIII. Treatment of Substance Abuse Problems - see extensive Substance Abuse Treatment Protocol and Substance Abuse Protocol Form including CAGE and MAST tool.

IX. Treatment of Housing Problems
A. Identification of shelter for the night while in primary care provider's office
B. Referral to City Housing Department for federally-subsidized housing, Section 8 housing, etc.
C. Referral to Department of Social Service for assistance with household expenses, including utilities

X. Access appropriate Health Insurance
A. Referral to Department of Social Services
B. Maryland Primary Care
C. Maryland Health Choice Program
D. Maryland Children Health Program
E. Others

XI. Resources on Homelessness, please see attached.

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Aye Lwin, M.D., Assistant Medical Director

Sources:

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Table 1: Resources on Homelessness

Resource•	*.1/r/eb.site*
Adversrchndhop./Exper1epc  5s{ugy•(aqu ftbUtto[ll es study based on > adver  EJ chitdhopp experiences)	http://www.acestudy.org
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StandUpforti  s	http://standupforklds.org/.
Substance Abuse and Mental. Health Services Administration National Center forTrauma lnforrnedCare	http: //www .samhsa.gov/nctic/
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11. Individuals with HIV/AIDS

I. Treatment guidelines for HIV/AIDS change frequently. Updates can be found at https://aidsinfo.nih.gov/guidelines.

II. HIV positive patients will be treated by the primary care providers with appropriate medication or referred to ID (e.g. Moore Clinic) after an assessment of the patient's immediate medical needs, depending on their comfort level.

III. Regular follow-ups will be made with the primary care provider. The CD4 counts and viral load should be checked every 3-6 months at a minimum. Patients diagnosed with HIV/AIDS are reported to the local health department.

IV. Indications for Antiretroviral Therapy

A. ART is now recommended for all HIV-infected patients to reduce disease progression and virus transmission.
   1. Strength of recommendation varies by pre-treatment CD4 count: CD4 <350**(AI)**; CD4 350–500 **(AII)**; CD4 >500 **(BIII)**.
   2. The decision to initiate ART should be individualized for each patient and may incorporate assessment of the following factors:
      * Risk of progression to illness or death if untreated
      * Readiness and willingness to adhere to therapy; potential barriers to adherence, psychosocial issues
      * Co-morbidities and coexisting conditions
      * Risk of HIV transmission to others if untreated
      * Risk of toxicities and drug-drug interactions

B. Highest priority for ART treatment initiation:
   * Pregnant
   * AIDS-defining illness
   * HIV associated nephropathy
   * HIV associated dementia
   * Hepatitis B co-infection
   * Acute HIV-infection

V. Recommended Treatment

A. Genotype testing should be performed at the time of diagnosis if the viral load is >1,000 copies/ml. Consider repeat testing when treatment is initiated.
B. Three antiretroviral drugs are used. Treatment needs to be individualized depending on the CD4 count, viral load, and the compliance of the patient
C. Goal of Treatment: Reduction in viral load below detectable levels.
D. Continue treatment without interruption to reduce resistance mutations.
E. Pregnancy – preferred ART:
   1. NRTI's: Lamivudine, Zidovudine,

2. NNRTI: Nevirapine,
3. PI's: Atazanavir/Ritonavir, Lopinavir/Ritonavir

VI. Monitoring ART

A. Obtain VL within 2-4 weeks after initiation of therapy (1 log drop or greater indicates adequate response)
B. Repeat VL q4-8 weeks until VL<200, then every 3-4 months if stable
C. Repeat CBC, LFT's, and creatinine every 3-6 months after initiating therapy
D. CD4 count can be checked every 6-12 months after virologic suppression met and above opportunistic threshold.
E. If the patient has stopped therapy, it should be restarted as soon as possible.

VII. Basic Prophylaxis Timetable

A. When diagnosed with HIV initially
   1. Administer necessary vaccines
   2. Get baseline lab work (CBC, CMP, VL, CD4, genotype, G6PD, toxoplasma IgG, RPR, gonorrhea, chlamydia, Hepatitis A,B,C, CMV IgG, VZV IgG (if no Hx of chickenpox), PPD or Quantiferon TB Gold
   3. Do baseline physical, pap smear if due
   4. Assess for other needs (e.g.: counseling, housing, health insurance)
   5. Assess allergies
   6. Discuss advanced directives

B. At CD4 of < 200, Prior AIDS-defining illness, or thrush
   1. Begin PCP prophylaxis
      - Most common prophylaxis is SMZ/TMP DS daily, every other day, or, 1 three times a week.
   2. If allergic to sulfa drugs, the patient should use Dapsone, Pyrimethamine, Leukovorin, Pentamidine, or Atovaquone.

C. At CD4 of < 100
   1. Continue above therapies
   2. Begin prophylaxis for Toxoplasma
      - Prophylaxis is the same as for PCP, if taking Bactrim DS
      - Alternatives are Bactrim SS, Dapsone + Pytimethamine + Leukovorin, and Atovaquone.
      - If using PCP prophylaxis that is not a preferred regimen for toxoplasma when CD4 drops <100, should change regimen if toxoplasma IgG antibodies are positive.

D. At CD4 of < 50
   1. Continue above therapies
   2. Begin MAC Prophylaxis
      - Most common prophylaxis is Azithromycin 1200 mg weekly or

Clarithromycin 500 mg B.I.D.
- Alternative is Rifabutin

VIII. Selected Commonly Seen Complications & Their Prophylaxis/Treatment

A. Tuberculosis - PPDs should be administered yearly.
1. If the skin test is +, with ≥5mm induration, but a chest x-ray is negative, referral to the Local Health Department should take place immediately and the patient should begin a 9 month course of INH and B6 therapy. Liver enzymes should be done regularly to monitor for elevation.
2. If the skin test is +, with a ≥5mm induration, and the chest x-ray is positive, the patient should be sent immediately to the hospital so that a rigorous and extensive medication regimen can begin. The patient will likely be hospitalized for at least a month to ensure that medication is being administered properly and in a timely manner.

B. Diarrhea
1. Ensure hydration and appetite
2. Assess for associated symptoms, such as pain with swallowing or defecation
3. Obtain stool for cultures - look for parasites, WBCs, c.diff, etc.
4. Treat as appropriate from the culture results
5. Refer immediately to hospital if dehydrated, as evidenced by:
   a. Orthostatic hypotension
   b. Poor skin turgor
   c. Dry oral mucosa or sunken, glassy eyes

C. HIV Wasting Syndrome
1. Ensure appetite and hydration
2. Assess for presence or lack of other GI or endocrine disease
3. Assess for malignancies
4. Assess for febrile symptoms
5. Megace, Marinol, and Nandrolone may be used as indicated.
6. Prescribe nutritional supplement, if covered, (e.g.: Ensure) 1 can three times a day with regular meals

D. Mental Health Needs, Including Substance Abuse
1. Identify and diagnose the correct mental health problem
2. Treat medically, as able, and
3. Offer services of in-house counseling department
4. If the patient suffers from chemical addiction:
   a. Manage detoxification and rehabilitation, if can meet patient's needs and patient is motivated.
   b. Refer to another program for detoxification and continue to manage the patient's rehabilitation needs through counseling and palliative medical care. ***(See extensive Substance Abuse Protocol)***

E. Sexual Dysfunction
   1. Identify cause: endocrine; substance abuse; cardiovascular
   2. Hypogonadism is more common than in general population.
   3. Sildenafil (VIAGRA) may be used where indicated
      a. Concomitant use of the protease inhibitor RITONAVIR may substantially increase serum concentration of sildenafil (VIAGRA). Visual disturbances, decreased blood pressure, syncope, and prolonged erection were reported in volunteers exposed to high doses of sildenafil. To decrease the chance of adverse events in patients on ritonavir, 25 mg dose of sildenafil is recommended.
      b. Safe sex counseling must be discussed.

F. Cervical Cancer
   1. Consider initial screening within 1 yr of onset of sexual activity.
   2. Pap Q6mon x2, then annual if normal.
   3. HPV testing **alone** is not recommended for follow-up of abnormals

IX. Selected Situations for Referrals - See Referral Protocol

A. Karposi's sarcoma – ID, oncology
B. CMV retinitis - hospital
C. PCP, active - hospital or outpatient
D. TB, active - hospital or outpatient
E. MAC, active - hospital or outpatient
F. Change in mental status or new seizures - hospital
G. Severe Oral Candidiasis with Dysphagia - hospital or outpatient
H. Positive RPR - Local Health Department
I. Positive PPD & Positive chest x-ray - Local Health Dept and hospital
J. Pneumonia - hospital

X. Recommended Immunizations

A. Flu Vaccine - annual, inactivated only
B. Pneumonia Vaccine:
   1. If no prior PPV23->Give PCV13->after 8wk or more give PPV23 (option to wait for CD4 ≥ 200 on ART before giving PPV23 dose).
   2. If PPV23 has been given->Give PCV13 after 1yr or more.
   3. Give 2nd PPV23 after 5 or more yr

C. Hepatitis A vaccine if chronic liver disease, IVDA, and MSM populations
D. Hepatitis B vaccine – preferably before CD4 falls to < 350
E. The following live vaccines may be used if otherwise indicated, only if CD4 > 200:
   1. MMR
   2. Varicella
   3. Zoster-Zostavax
   4. Yellow Fever

5. HPV- up to age 26 can be given CD4 < 200 (9-26 yrs)

F. Shingrix- recombinant vaccine for Zoster (in active vaccine)
-for all HIV patients over the age of 50 regardless of their CD4 count.

If additional risk factors exists:

G. Meningococcal vaccine ACWY (ages 16 through 23 years old)

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12. Individuals in Need of Substance Abuse Treatment

I. Identification & Definition of Substance Abuse Problem

A. Entrance into Program
1. According to DSM-IV criteria
2. Patient self-referral

B. Comprehensive History & Physical, focusing on:
1. Duration of substance abuse
2. General mental health
3. Presence of or Risk Factors for sexually transmitted &/or blood-born diseases
4. Identify "self-treatment" for underlying issues, e.g. depression, schizophrenia

C. Use of the Substance Abuse Protocol form including CAGE & MAST Tool or another screening tool. (Please see sample tool at the end of this guideline.)
1. Define duration of abuse
2. Drug(s) of abuse
3. Route of administration
4. Desire for treatment and rehabilitation
5. General tract for treatment method

D. Comprehensive Lab work & Other Diagnostic Work
1. Automated chemistry panel
2. Hepatitis diagnostic profile
3. Urine drug screens
4. HIV testing (with pre- and post-test counseling)
5. PPD skin test for TB (annually)
6. Chest x-ray if anergic (no reaction to controls)
7. STD screening, including syphilis serology

II. Detoxification Resources

A. In-house Resources
1. Primary care providers

B. Outside Out-patient Resources
1. SAMMSA 1-800-622-HELP (National Helpline)
2. Beacon Health 1-800-888-1965 for referral options
3. BACHS HealthCare 410-241-6317
4. Other options included:
    - Turke House 410-233-0684
    - Powell Recovery 410-276-1773
    - Baltimore Recovery Center
    - Baltimore Addiction Services
    - Glenwood Life Counseling Center

- Jones Falls Counseling Center

5. Outpatient Addiction Services at GBMC

C. Outside In-patient Resources
   1. Baltimore Addiction Services
   2. Mercy Hospital
   3. JBMC
   4. Other local hospitals (for alcohol withdrawal)

III. Detoxification Plan for In-house Treatment

A. Tapering off abused substance - only possible with benzodiazepines (e.g.: Xanax, Ativan or Valium)
   Gradual decrease of abused substance done by in-house primary care providers

B. Substitution for abused substance
   1. Opiates (e.g.: heroin, morphine, demerol, percocet, etc.)
      a. Drug of choice for detoxification is clonidine
      b. Other drugs used for symptomatic relief
         i. Motrin for aches and pains
         ii. Doxepin for insomnia
         iii. Imodium for diarrhea
         iv. Bentyl for lower bowel cramps
         v. Zantac for stomach aches
   2. Benzodiazepines (e.g.: Xanax, Valium)
      a. Drug of choice is Phenobarbital
      b. Primary care providers use an established conversion formula to establish dose
   3. Stimulants (e.g.: cocaine)
      Drug of choice is a Tricyclic anti-depressant
   4. Depressants (e.g.: alcohol)
      a. Drug of choice is Librium
      b. Consider tegretol taper (it is non-sedating)
      c. 5 days thiamine 100 mg PO QD and consider folic acid 1mg PO QD

IV. In-house Rehabilitation Services—To be initiated immediately after Detox (if necessary) but within 14 days of initial diagnosis

A. Regular medical follow-up
   1. Health maintenance
   2. Periodic drug screening
   3. Medications
      a. To aid sleep.
      b. To cope with pain
      c. To supplement diet

B. Mental Health follow-up
    1. Individual therapy
    2. Group therapy
    3. Support groups

V. Outside Rehabilitation Services

A. Glenwood Life Counseling Center
B. Baltimore Addiction Services
C. Jones Falls Counseling Center
D Baltimore Recovery Center
E. Outpatient Addiction Services at GBMC

VI. Other Support Services

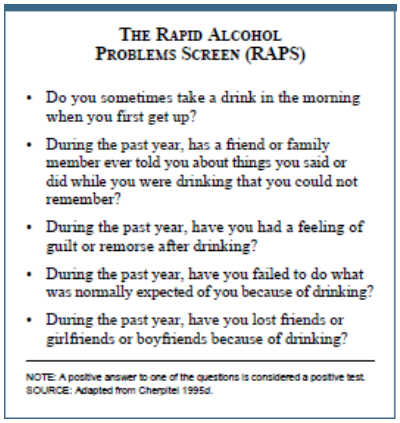
A Alcoholics Anonymous
B. Narcotics Anonymous

VII. Tracking & Aftercare

A. Primary care providers record all aspects of patient care in patient's chart
B. Evaluate and Assess patient progress at each visit
C. Review of client records weekly to:
    1. Ensure continuity of care
    2. Adherence to program protocols, including at least two follow-up visits within 30 days of initiation of treatment
    3. Assess and remind them that detox is not simply replacement (e.g. Suboxone or methadone)

D. Long-term follow-up
    1. Physical health by primary care providers
    2. Mental health by in-house department

Sample Screening Tool:



THE RAPID ALCOHOL PROBLEMS SCREEN (RAPS)

- Do you sometimes take a drink in the morning when you first get up?
- During the past year, has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?
- During the past year, have you had a feeling of guilt or remorse after drinking?
- During the past year, have you failed to do what was normally expected of you because of drinking?
- During the past year, have you lost friends or girlfriends or boyfriends because of drinking?

NOTE: A positive answer to one of the questions is considered a positive test.
SOURCE: Adapted from Cherpitel 1995d.

The Rapid Alcohol Problems Screen (RAPS) asks questions similar as the CAGE test, but from a different perspective. One "yes" answer on the RAPS4 test indicates a possible alcohol abuse problem and the results have shown to be very accurate across gender and ethnic groups. (1997)

The RAPS4 Questions (2007)

The RAPS4 test has been found to be highly effective in detecting alcohol dependence in the past year across gender and ethnic groups-- white, black and Hispanic.

Research has also shown that the RAPS4 is more effective than the CAGE test, which has traditionally been the most widely used test in clinical settings.

The RAPS4 gets its name from the questions it poses to the patient which pertain to remorse (R), amnesia (A), performance (P), and starter drinking behavior (S). Each question pertains to the patient's behaviors in the past year.

1. Have you had a feeling of guilt or remorse after drinking?
2. Has a friend or a family member ever told you about things you said or did while you were drinking that you could not remember?
3. Have you failed to do what was normally expected of you because of drinking?
4. Do you sometimes take a drink when you first get up in the morning?

A "yes" answer to at least one of the four questions suggests that your drinking is harmful to your health and well-being and may adversely affect your work and those around you.
If you answered "no" to all four questions, your drinking pattern is considered safe for most people and your results do not suggest that alcohol is harming your health.

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Sources:

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13. Immunizations

The immediate goal of administering immunizations is the prevention of disease; the ultimate goal is eradication of disease. To accomplish these goals, physicians must maintain timely immunizations as a high priority in the care of children, adolescents, and adults. This is even more important in children in whom immunizations provide the best available defense against many dangerous childhood diseases. Physicians should ensure that the primary series of vaccinations are given before children are 2 years old in order for them to be protected during their most vulnerable period.

This protocol represents the current recommended Childhood Immunization Schedule from the American Academy of Pediatrics, the Center for Disease Control and the Maryland Department of Health and Mental Hygiene.

Primary Immunizations for Children Beginning Immunization Under 4 Months of Age

At Birth	Hep B(1)
2 Months	Hep B, DTaP(2), Hib(4), IPV(5), PCV (8), RV(11)
4 Months	DTaP, Hib, IPV, PCV, RV
6 Months	Hep B, DTaP, Hib, IPV, PCV, RV
12-15 Months	MMR(6), Var(7), DTaP, Hib, PCV, HepA(10)
18 Months	Hep A
4-6 Years	DTaP, IPV, MMR, Var
11-12 Years	TdaP(3), Men(9), HPV(12)
16 Years	Men

Primary Immunizations for Children Beginning Immunizations Between 4 Months and 6 Years of Age

First Visit (>/ 4 months of age)	DTaP, IPV, Hib, Hep B, PCV, RV Var, MMR and HepA should be given as soon as child is 12 months
Second Visit (1month after 1st visit)	DTaP, IPV, Hib(4), Hep B, RV
Third Visit (1 month after 2nd visit)	DTaP, IPV, Hib, PCV, RV

Fourth Visit (6 months after 3rd visit) DTaP, Hib, Hep B, PCV

Additional Visits (Age 4-6 years) DTaP[(2)], IPV[(5)], MMR, Var

Age 11-16 Years Tdap, Men, HPV

Immunization Schedule for Persons 7 Years of Age and Older Who Were Not Vaccinated at the Recommended Time in Early Infancy

First Visit Tdap, IPV, MMR, Hep B, Hep A Var[(7)]

Second Visit (6-8 weeks after 1st visit) Td[(3)], IPV, MMR, Hep B, Var

Third Visit (6 months after 2nd visit) Td, IPV, Hep B, Hep A

Additional Visits Tdap, Men, HPV (given once child is 11 years of age and older)

Notes

1) Hep B - All newborns should receive the first dose of Hep B vaccine within 24 hours of birth if medically stable. Four doses of vaccine may be administered if combination vaccines are used. Children who have not previously received 3 doses of Hep B vaccines should initiate or complete the series. The second dose should be administrated at least 1 month after the first; the third dose should be at least 4 months after the first dose and at least 2 months after the second.

2) DTaP - DTaP should be used in children less than 7 years of age. Use DT pediatric vaccine when Pertussis vaccine is contraindicated. The fourth dose of DTaP can be given as early as 12 months of age if administered at least 6 months after the third dose of DTaP. If the fourth dose of DTaP is given after the fourth birthday, a fifth DTaP is not necessary.

3) Tdap (Td) - Td should be used for children 7 years of age and older. Tdap should be substituted for a single dose of Td in the primary catch up series. Give a Tdap dose to adolescents 11-18 years who have not previously received a dose. Boost every 10 years with Td. Administer one dose of Tdap to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks gestation) regardless of years from prior Td or Tdap vaccination.

4) Hib - Four doses may not be needed if the Hib series is begun late in infancy; one dose at ≥15 months of age precludes the need for more doses. Hib is not routinely recommended for patients 5 years or older. However, 1 dose of Hib vaccine should be administered to unimmunized persons aged 5 years or older who have asplenia or HIV infection.

5) IPV - If the third IPV is administered after the fourth birthday, a fourth dose is not necessary.

6) MMR - MMR should be administered on or after the first birthday. The second dose of MMR is routinely recommended at 4-6 years of age. It may be administered at any visit >/12 months of age, provided at least 1 month has elapsed since receipt of first dose. During measles outbreaks, health departments may make recommendations to protect their communities. Health departments may recommend an additional dose for adults, an earlier second dose for children 1- 4 years, or an early dose for infants 6 – 11 months of age who live in the affected area. Infants who get a dose of MMR before their first birthday should get two more doses as routinely recommended.

7) Var - Varicella may be administered to susceptible children, i.e. those who lack a reliable history of chicken pox disease, at any time at or after the first birthday. A second dose of varicella is recommended routinely at 4-6 years. Give 2 doses of varicella vaccine to all older children and adolescents without evidence of immunity.

8) PCV - PCV13 is recommended as a series of 4 doses at 2, 4, 6 and 12-15 months of age. If the first dose is administered at 2-6 months of age, 4 doses should be given. All additional doses can be given at least 6 weeks apart. If the first dose is given at 7-11 months of age, 3 doses are recommended. For immunization beginning at 12-23 months, 2 doses are required. If the vaccine is given after 24 months, only one dose is necessary. Children who have begun the series with PCV7 should complete it with PCV 13. Pneumococcal vaccine is recommended for children at moderate to high risk of invasive pneumococcal disease up to 59 months of age. This vaccine is not required for healthy children > 5 years of age.
For children aged 6- 18 years with immunodeficiencies, hemoglobinopathies, renal disease,asplenia, chronic heart disease or chronic liver disease, a dose of PCV13 should be administered followed by a dose of PPSV23 at least 8 weeks later.

9) Meningococcal - MenACWY vaccine is recommended for 11-12 years with a booster dose at 16 years. Administer at age 13-18 years if not previously vaccinated. MenACWY may be given to younger children with asplenia or complement deficiency at high risk for invasive disease.
Teens (age 16-18 years) should be vaccinated routinely with the Meningococcal B vaccine (MenB). Give 2 doses of either MenB vaccine. Persons at high risk can be vaccinated with MenB beginning at age 10.

10) Hepatitis A - Hepatitis A vaccine is recommended for all children 12-23 months of age. Two doses should be administered, given at least 6 months apart. Older unvaccinated children should be vaccinated.

11) RV - The Rotavirus (Rotateq) vaccine is recommended for all children between 6 and 12 weeks of age. Do not start the series later than 15 weeks, 0 days. All three doses should be received by 8 months, 0 days of age. Do not administer after 8 months, 0 days. The doses

should be administered at 4 to 10 week intervals. The two dose vaccine (Rotarix) should be administered at 2 and 4 months.

12) HPV- Give 2 dose series of HPV9 to girls and boys 11-12 years on a 0, 6 month schedule. Give a 3 dose series of HPV9 to boys and girls 15 years or older on a 0, 1, 6 month schedule. May give as early as 9 years. Administer HPV vaccine beginning at 9 years to children with a history of sexual abuse.

13) The seasonal influenza vaccine is recommended for all children 6 months of age and older. Children under 9 years who are receiving that vaccine for the first time should receive 2 doses, 4 weeks apart. The live attenuated influenza vaccine is an available option this influenza season.

Recommended Adult Immunizations

Adults 19 years and older should receive the following vaccines if age appropriate or because of medical conditions or risk factors:

Influenza vaccine
Tdap/Td vaccine
Varicella vaccine
HPV vaccine
Herpes Zoster vaccine
MMR vaccine
Pneumococcal vaccine (PPSV23 and PCV13)
Meningococcal vaccine
Hep A vaccine
Hep B vaccine

Notes

1) The influenza vaccine is recommended for all adults. The live attenuated influenza vaccine is an option for adults 49 years of age and younger.

2) Administer a 1-time dose of Tdap to all adults who have not received Tdap previously. Administer one dose of Tdap to pregnant women during each pregnancy (preferred during 27-36 weeks gestation), regardless of number of years since prior Td or Tdap vaccination. Boost with Td every 10 years.

3) All adults without evidence of immunity to varicella should receive 2 doses of the varicella vaccine unless medically contraindicated.

4) HPV vaccination is recommended for *all adults through age 26 years*.

5) Two doses of zoster vaccine, 2 – 6 months apart, are recommended for adults 50 years or older.

6) Adults born before 1957 generally are considered immune to measles and mumps. All adults born in 1957 or later who lack documentation of measles, mumps or rubella immunity should receive 2 doses of MMR vaccine unless contraindicated.

7) Vaccinate all persons with PPSV23 with the following indications: Chronic lung disease, chronic cardiovascular disease, diabetes mellitus, chronic alcoholism, chronic liver disease, chronic renal failure, functional or anatomic asplenia and immunocompromising conditions. Vaccinate all adults aged 65 and older.

8) Adults aged 19 years or older with immunocompromising conditions including chronic renal failure, functional or anatomic asplenia, and who have not previously received PCV13 or PPSV23 should receive a single dose of PCV13 followed by a dose of PPSV23 at least 8 weeks later. Adults aged 19 or older with the aforementioned conditions who have previously received one dose of PPSV23 should receive a dose of PCV13 one or more years after the last PPSV23 dose was received. Administer 1 dose of PCV13 to immunocompetent adults aged 65 years or older, followed by 1 dose of PCSV23 at least 1 year later.

9) Meningococcal vaccine (MenACWY and MenB) should be administered to adults with anatomic or functional asplenia, complement deficiencies or HIV infection.

10) Vaccinate any person seeking protection from hepatitis A and those with the following indications: men who have sex with men, intravenous drug users, persons with chronic liver disease or those traveling to or working in countries where hepatitis A is endemic. Homelessness has been added as an indication for routine vaccination.

11) Vaccinate any person seeking protection from hepatitis B or any person with the following indications: health care personnel, diabetics, persons with HIV, end-stage renal disease or chronic liver disease, sexually active persons not in long term monogamous relationships, men who have sex with men and intravenous drug users.

12) One dose of Hib vaccine should be administered to persons who have asplenia or are undergoing splenectomy if not previously vaccinated.

COVID-19 vaccines received Emergency Use Authorization in the United States in December of 2020 for the prevention of COVID-19 infection. The ACIP issued an interim recommendation for the Pfizer BioNTech Covid-19 vaccine in persons 16 years and older. This recommendation was later amended to include persons 12 years and older. The Moderna COVID-19 and the Johnson & Johnson/Janssen vaccines also received interim recommendations by the ACIP for persons 18 and older. Pfizer BioNTech and Moderna are mRNA vaccines. Janssen is a viral vector vaccine. The Pfizer BioNTech vaccine was approved by the FDA for individuals 16 and older on August 23, 2021.

Vaccine abbreviations:
Hep B - hepatitis B
Hep A - hepatitis A
DTaP - diphtheria and tetanus toxoids and acellular pertussis
Td - tetanus toxoid (full dose) and diphtheria toxoid (reduced dose)
Tdap - tetanus and diptheria toxoids and acellular pertussis
Hib - haemophilus influenza type B conjugate
IPV - inactivated poliovirus
MMR - measles, mumps, rubella
Var - varicella
PCV - pneumococcal conjugate vaccine
Men - meningococcal vaccine
HPV - human papilloma vaccine
PPSV- pneumococcal polysaccharide vaccine

Formatted: Spanish (Latin America)

Written By:
Frances Bird, M.D., Staff Physician
Sources:
Advisory Committee on Immunization Practices(ACIP) Recommended Immunization Schedule for Persons Aged 18 Years or Younger -Unites States, 2021, Morbidity and Mortality Weekly Report MMWR/2021 Feb 12;70:189-192

Advisory Committee on Immunization Practices(ACIP) Recommended Immunization Schedule for Adults Aged 19 Years and Older _ United States, 2021, Morbidity and Mortality Weekly Report MMWR/2021 Feb 12; 70(6):193-196

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14. Pediatric and Adult Asthma

Asthma is a chronic disease whose prevalence, morbidity, and mortality have continued to increase despite our understanding of its pathophysiology and the development of new pharmacologic agents. The highest incidence is in the pediatric population, where it affects approximately 8% of children, yet a large population of adults also struggles with asthma. Additionally, asthma is a leading cause of pediatric emergency room visits and hospitalizations.

This protocol represents updated guidelines on the diagnosis and management of asthma.

I. At the initial visit, a comprehensive history and physical examination should be performed. Essential elements of the history that should be documented include:
- A. Symptom frequency during both the day and the night
- B. Precipitating triggers of symptoms
- C. Pattern and frequency of medication used to control symptoms
- D. Age of onset of wheezing
- E. # of E.R. visits and hospitalizations for asthma exacerbations
- F. # of days absent from school/work due to symptoms
- G. Family history of asthma
- H. Interference with normal activity
- I. Exacerbations requiring oral systemic corticosteroids
- J. Screen for GERD
- K. Smoking history/environmental tobacco smoke exposure

II Diagnosis of asthma:
- A. Presence of signs/symptoms of recurrent airway obstruction by history/exam.
  1. Recurrent cough, wheezing, chest tightness, difficulty breathing.
  2. Symptoms occur/worsen at night, with exercise/URI/allergen exposure/stress
- B. In all patients ≥ 5, use spirometry to document at least partial reversibility of airway obstruction
- C. Consider other causes of obstruction

III. Pulmonary function testing should be done in any child able to perform reliable (usually 5 years and older):
- A. Peak flow measurement
  OR
- B. Spirometry

IV. The severity of asthma helps to assess after initialing Rx and should be classified as follows:

A. Intermittent
- -Use of SABA to relieve symptoms ≤ 2 times per week
- -One or no exacerbation needing oral steroids per year
- -Normal lung function test
- -≤ 2 nocturnal awakenings a month

B. Mild Persistent
-Use of SABA to relieve symptoms >2 days per week
-2 or more exacerbations needing oral steroids per year
-Normal lung function test
-Minor interreference with normal activities
-nocturnal awakenings not more than 1 time a week

C. Moderate Persistent
-Daily need for SABA for symptom relief
-Some limitation in normal activity
-Abnormal lung function test
-more than one nocturnal awakening a week

D. Severe Persistent
-Presence of >3 of the following:
- Troublesome daytime asthma symptoms > 2 times per week.
- -Nocturnal awakening due to asthma, reliever needed >2 times per week.
- Activity limitation due to asthma-Extreme
- Reliever medicine needed several times/day (SABA) -abnormal lung function test.

V. Step-wise approach to pharmacologic management **(First check adherence to medications, appropriate inhaler technique, environmental triggers, and comorbidities)**:

A. Intermittent
-Short acting Beta 2 Agonists
-Low does budesonide-formoterol (FHA 160/4.5)

B. Mild Persistent
-Short acting Beta 2 Agonists
-Low doses of Inhaled Corticosteroids (preferred)
-Leukotriene Modifiers (alternative)

C. Moderate Persistent
-Short acting Beta 2 Agonists
-Inhaled Corticosteroids (medium dose)
-± long acting Beta 2 Agonists (preferred)
-± Leukotriene Modifiers (alternative)

D. Severe Persistent
-Short acting Beta 2 Agonists
-Inhaled Corticosteroids (high doses)-refer to a specialist (Pulmonology, Allergist) for biological agents.
-+ long acting Beta 2 Agonists
-Consider Oral Corticosteroids
-Consult asthma specialist

D. Step down if possible − if asthma has been well controlled for at least three months. Only consider:

- LABA- for children 5 years and over.
- LAMA for children 6 years and over

VI. Care Management:

< Educate on disease process, medication use, compliance with controller medications, inhaler/spacer technique, and peak flow monitoring; offer educational handouts on asthma, available in each physician office.
< Develop an individualized Asthma Care Plan with the patient, reviewing treatment goals, self-monitoring results, medication lists, and barriers to meeting goals at each visit. Asthma Care Plans should be reviewed at each appropriate visit and up-dated as necessary to improve asthma control and patient adherence.
< Discuss avoidance of environmental triggers, including tobacco smoke
< Stress importance of follow-up visits
< Need for compliance with preventer medications to minimize exacerbations and improve quality of life
< Document patient's/family's understanding of disease process and management.

VII. Follow Up:

< Visit PCP at least every 3 months
< Complete history and physical annually
< Review the Asthma Action Plan at least annually after it is initially completed with the patient. Updates to the Care Plan can be made more frequently if asthma status is changing
< Review control of symptoms; modify medications if necessary; re-discuss asthma action plan; emphasize the importance of compliance with daily controller medications; monitor growth and quality of life
< If the patient is achieving good outcomes, document this in continuation notes
< Track # of acute asthma episodes: office and ER visits and hospitalizations
< Annual influenza vaccine recommended, and for adults19-64 years of age, a single pneumococcal polysaccharide vaccination is recommended.
< Patients may be referred to an asthma health education class or to a community asthma program to help with disease management and implementation of environmental control measures.

VIII. Please note: HEDIS quality assurance guidelines require treatment with a controller medication for persistent asthma if a patient has:

A. Been prescribed asthma medication on four occasions

OR

B. Two outstanding asthma visits and two asthma medications prescribed

OR

C. One emergency room visit for asthma

OR

D. One hospitalization for asthma

HEDIS also requires that patients identified as having persistent asthma have a ratio of controller to total asthma medications of 0.5 or greater.

Written by:
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Sources:

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3. *US Department of Health and Human Services. 1997. National Asthma Education and Prevention Program: Expert Panel Report II: Guidelines for the Diagnosis and Management of Asthma, 97:4051.*
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5. *National Heart, Lung, and Blood Advisory Council, Asthma Expert Working Group: Guidelines for the Diagnosis and Treatment of Asthma. April 2014 http://www.nhlbi.nih.gov/files/docs/resources/lung/NHLBAC-Asthma-WG-Report.pdf*
6. *Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention 2014. www.ginasthma.org*
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15. LYME DISEASE

Lyme Disease

Lyme disease was first recognized in the United States in 1975, after a **mysterious outbreak of arthritis near Lyme, Connecticut.** Since then, reports of Lyme disease have increased dramatically, and the disease has become an important public health problem in some areas of the United States.

Lyme disease is an infection caused by the corkscrew-shaped bacterium *Borrelia burgdorferi*, a member of the family of spirochetes.

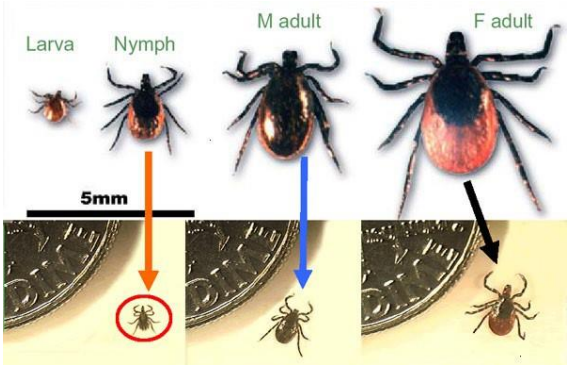
How Ticks Spread the Disease

The bite of ticks spreads the bacterium that causes Lyme disease. The black-legged deer tick, *Ixodes scapularis*, which normally feeds on the white-footed mouse, the white-tailed deer, other mammals, and birds, is responsible for transmitting Lyme disease bacteria to humans in the northeastern and north-central United States.

Nymphal ticks are the primary source for transmitting Lyme disease bacteria to humans, probably because nymphs are more likely to feed on people and are rarely noticed because they are tiny, less than 2mm. Thus, nymphs have the necessary time to feed and transmit the bacteria, typically after feeding for 2 or more days, but it can happen more quickly. Also, nymphal ticks feed during the spring and summer months when people spend the most time outdoors.

Ticks can attach to any part of the human body but are often found in hard places to see and hairy areas such as the groin, armpits, and scalp. In many cases, the tick must be attached for 48 hours or more before the bacteria can be transmitted. Not all deer ticks are infected with the bacteria that cause Lyme disease, and only a small percentage of people bitten by deer ticks actually become sick.

Ixodes ticks are much smaller than the common dog or cattle ticks. In their larval and nymphal stages, they are no bigger than the eye of a common sewing needle. Adult ticks are larger, about the size of a small apple seed.



Adult ticks can also transmit the bacteria, but because adult ticks are larger and more noticeable, they are more likely to be removed from a person's body within a few hours, and therefore are less likely to have sufficient time to transmit the bacteria. Moreover, adult *Ixodes* ticks are most active during the cooler months of the year, when people spend less time outdoors and additional clothing may provide added protection.

Ticks search for host animals from the leaf litter of the forest floor, especially during the nymph stage, or from the tips of grasses and shrubs, during the adult stage, and crawl onto animals or persons they contact. Ticks found on the scalp usually have crawled there from the lower parts of the body. Ticks can feed on blood by inserting their mouthparts into the skin of a person or animal. They are slow feeders: a complete blood meal can take several days. As they feed, their bodies slowly enlarge.

Campers, hikers, outdoor workers, and others are commonly exposed to ticks when frequenting wooded, brushy, and grassy places. People living in houses built in wooded areas where infected ticks are common may also have increased exposure to the Lyme disease bacteria. The risk of exposure to ticks is greatest in the woods and in the edge area between lawns and woods of properties, but ticks can also be carried by animals into lawns and gardens.

Geographic Distribution

Lyme disease has a wide distribution in northern temperate regions of the world. In the United States, the highest incidence occurs in the following regions:

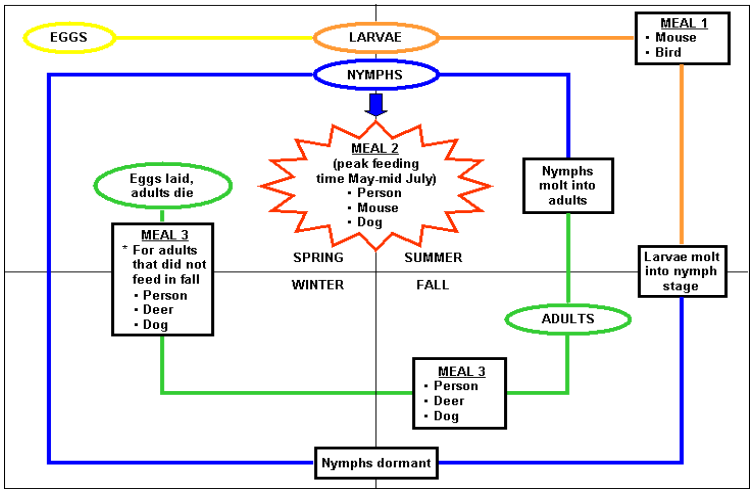
- Northeast, from Massachusetts to Maryland
- North-central states, mostly limited to Wisconsin and Minnesota
- West coast, particularly northern California

For Lyme disease to exist in an area, three closely interrelated elements must be present in the natural environment: (1) animals that carry Lyme disease bacteria, (2) ticks that can transmit the bacteria, and (3) mammals, such as mice and deer, that provide food for

the ticks in their various life stages. In highly endemic areas, as many as 50 percent of deer ticks may carry Lyme disease bacteria (Borrelia burdorferi).

Life Cycle of Ticks That Cause Lyme Disease

Knowing the complex life cycle of the ticks that transmit Lyme disease bacteria is important in understanding the risk of getting Lyme disease and in preventing it.



The life cycle of the deer tick requires 2 years to complete. Adult ticks feed and mate on large animals, especially deer, in the fall and early spring. Female ticks then drop off of these animals to lay eggs on the ground. By summer, eggs hatch into larvae.

Larvae feed on mice and other small mammals and birds in the summer and early fall. The larvae are inactive until the next spring when they change into nymphs.

Nymphs feed on small rodents and other small mammals and birds in the late spring and summer and molt into adults in the fall, completing the 2-year life cycle.

Larvae and nymphs typically become infected with Lyme disease bacteria when they feed on small animals infected with Lyme bacteria, particularly the white-footed mouse. The bacteria remain in the tick as it changes from larva to nymph to adult. Infected nymphs and adult ticks then bite and transmit Lyme disease bacteria to other small rodents, other animals, and humans.

Lyme Disease in Domestic Animals

Domestic animals may become infected with Lyme disease bacteria and some of these animals; dogs for instance, may develop arthritis. Domestic animals can carry infected ticks into areas where humans live. Studies of a possible increased risk of Lyme disease among pet owners is inconclusive.

Symptoms and Signs of Lyme Disease

Early Lyme Disease: The early stages of Lyme disease is usually marked by one or more of the following symptoms and signs:

- Fatigue
- Chills and fever
- Headache
- Muscle and joint pain
- Swollen lymph nodes
- A characteristic skin rash shaped like a bull's eye, called erythema migrans

Erythema migrans rash is a red circular patch that appears at the site of the tick bite usually within 3 days to 1 month after the bite of an infected tick. The patch then grows larger. Sometimes many patches appear, in varying shapes and sizes, depending on their location. Common sites are the thighs, groin, trunk, and armpits. The center of the rash may clear as it enlarges, resulting in a "bull's-eye" appearance. The rash may be warm, but it usually is not painful. However, not all rashes that occur at the site of a tick bite are due to Lyme disease. An allergic reaction to tick saliva often occurs at the site of a tick bite. The resulting allergic reaction rash can be confused with the rash of Lyme disease. Allergic reactions to tick saliva occur within hours after the tick bite, usually do not expand, and disappear within a few days.

Late Lyme Disease: Some symptoms and signs of Lyme disease may not appear until weeks, months, or years after a tick bite:

- Arthritis is most likely to appear as brief bouts of pain and swelling, usually in one or more large joints, especially the knees.
- Nervous system abnormalities can include numbness, pain, nerve paralysis (often of the facial muscles), and meningitis (fever, stiff neck, and severe headache).
- Pericarditis.
- In some persons the rash never appears; in some, the first and only sign of Lyme disease is arthritis, and in others, nervous system problems are the only evidence of Lyme disease.

Lyme Disease and Pregnancy

Rarely, Lyme disease acquired during pregnancy may lead to infection of the placenta and possibly to stillbirth, but studies of women infected during pregnancy have found no

adverse effect to the fetus when the mother received appropriate treatment for her Lyme disease. Please see the Antibiotic Section for the appropriate treatment of pregnant women.

Diagnosis

Many of the symptoms of Lyme disease are similar to those of other diseases. The fever, muscle aches, and fatigue of Lyme disease can be mistaken for viral infections, such as influenza or infectious mononucleosis. Joint pain can be mistaken for other types of arthritis, such as rheumatoid arthritis, and neurologic signs can mimic those caused by other conditions, such as multiple sclerosis. On the other hand, other types of infections, arthritis, or neurologic disease can be misdiagnosed as Lyme disease.

Diagnosis of Lyme disease should take into account the following:

- History of possible exposure to ticks in areas where Lyme disease is known to occur,
- Symptoms and signs of the illness, and
- The results of blood tests used to detect whether the patient has antibodies to the Lyme disease bacterium.

Laboratory tests for Lyme disease must be interpreted in relation to the patient's clinical presentation. Both false-positive and false-negative test results may occur. Two tests that measure the body's production of antibodies to the Lyme disease bacterium are recommended: (1) an enzyme-linked immunosorbent assay, ELISA, or indirect immunofluorescence assay, IFA, followed by (2) a Western immunoblot of positive or equivocal samples. These tests do not detect infection until the body begins to produce detectable levels of antibodies to Lyme disease bacteria, usually 2-4 weeks after an infected tick bite. Even then, however, the tests aren't entirely foolproof. History and physical findings become ever so important.

Treatment and Prognosis

Lyme disease is treated with antibiotics. Several antibiotics are effective and are usually given by mouth but may be given intravenously in more severe cases. Patients treated in the early stages with antibiotics usually recover rapidly and completely. Most patients who are treated in later stages of the disease also respond well to antibiotics. A few patients who are treated for Lyme disease may have persistent or recurrent symptoms, and may require additional antibiotic treatment. Varying degrees of permanent damage to joints or the nervous system can develop in patients with late chronic Lyme disease. Typically these are patients in whom Lyme disease was unrecognized in the early stages or for whom the initial treatment was unsuccessful.

Antibiotics

Antibiotic	Adults	Children	Duration
Early Infection Lyme Disease (Local and Disseminated)			
Doxycycline (Vibramycin)	PO: 100 mg bid	2-4 mg/kg/d in two divided doses	10 to 21 days
Amoxicillin	PO: 500 mg tid	40-50 mg/kg/d in three divided doses	14 to 21 days
Cefuroxime axetil (Ceftin)	PO: 500 mg bid	30 mg/kg/d in two divided doses	14 to 21 days
Arthritis			
Doxycycline	PO: 100 mg bid	2-4 mg/kg/d in two divided doses	28 days
Amoxicillin	PO: 500 mg tid	40-50 mg/kg/d in three divided doses	28 days
Pregnant Women and Nursing Mothers			
Amoxicillin*	PO: 500 mg tid	40-50 mg/kg/d in three divided doses	14 to 21 days

*No medication is absolutely safe during pregnancy, therefore the physician should consult with the obstetrician before beginning any treatment. Doxycycline has toxic effects on the development of bone in the fetus. Doxycycline is not recommended for pregnant women and nursing mothers unless there is no other appropriate antibiotic available.

Other Forms of Lyme Disease Such as Late Arthritis, Pericarditis, and Meningitis

Please refer to Conn's Current Therapy 2009 or other up-to-date reliable source.

Prevention

***Tick Control**:* Removing leaves, leaf litter, and clearing brush around houses and at the edges of lawns may reduce the numbers of ticks that transmit Lyme disease. This is particularly important in the eastern United States, where most transmissions of Lyme disease are thought to occur near the home.

A relationship exists between the abundance of deer and the abundance of *Ixodes* ticks in the eastern United States.

Reducing and managing deer populations in geographic areas where Lyme disease occurs can reduce tick abundance. Removing plants that attract deer and constructing physical barriers may help discourage deer from coming near homes.

Personal Protection From Tick Bites

You can decrease the chance of being bitten by a tick by following a few precautions.

- Avoid tick-infested areas, especially in May, June, and July. Many local health departments and park or extension services have information on the local distribution of ticks.

- Wear light-colored clothing so that you can spot ticks more easily.
- Tuck pant legs into socks or boots and shirt into pants.
- Tape the area where pants and socks meet so that ticks cannot crawl under clothing.
- Wear a long-sleeved shirt for added protection.
- Spray insect repellent containing a 20-30% concentration of DEET on clothes and on exposed skin other than the face, or treat clothes, especially pants, socks, and shoes, with permethrin, which kills ticks on contact.
- Walk in the center of trails to avoid contact with over-grown grass and brush at trail edges.

Removal of Ticks

After being outdoors, remove your clothing and wash and dry it at a high temperature: inspect your body carefully and remove attached ticks with tweezers, grasping the tick as close to the skin surface as possible and pulling straight back with a slow steady force: avoid crushing the tick's body.

Preventive Antibiotic Treatment

A controlled study has demonstrated that a single dose of 200 mg of Doxycycline effectively prevents Lyme disease if given within 72 hours of a tick bite. Physicians must determine whether the benefits of using antibiotics outweigh the risks in any particular instance.

Lyme Disease Vaccine

The LYMErix vaccine has been withdrawn, after studies showed it to be ineffective in some cases and to occasionally cause Lyme disease and/or potentially harmful side effects. There are no other vaccines available for Lyme disease at this time. However, research on new vaccines against Lyme disease continues.

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Updated by:
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Sources:
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3. Division of Vector-Bourne Infectious Diseases
4. Mayo Clinic
5. Conn's Current Therapy 2009

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16. INDIVIDUALS WITH DIABETES MELLITUS

Diabetes is a chronic illness that requires continuing medical care and patient self-management education to prevent acute complications and to reduce the risk of long-term complications.

Classification

In 1997, the ADA issued new diagnostic and classification criteria; in 2003, modifications were made regarding the diagnosis of impaired fasting glucose (IFG). The classification of diabetes includes four clinical classes:

- **Type 1 diabetes** (results from ß-cell destruction, usually leading to absolute insulin deficiency).
- **Type 2 diabetes** (results from a progressive insulin secretory defect on the background of insulin resistance).
- Other specific types of diabetes (secondary to other causes, e.g., genetic defects in ß-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, drug or chemical induced).
- Gestational diabetes mellitus (GDM) (diagnosed during pregnancy).

Diagnosis

Criteria for Diagnosis

i. Type 1 typically present with acute symptoms of diabetes and markedly elevated blood glucose levels
ii. Type 2

A1C ≥6.5%	The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay.*
	OR
FPG ≥126mg/dl (7.0mmol/l)	Fasting is defined as no caloric intake for at least 8 hours.*
	OR
2-h plasma glucose ≥200mg/dl (11.1mmol/l) during an OGTT.	The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75g anhydrous glucose dissolved in water.*
	OR
Random plasma glucose ≥200mg/dl (11.1mmol/l)	In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis

*In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing

iii. Pre-diabetes includes impaired fasting glucose (IFG) and impaired glucose tolerance (IGT). Both categories are risk factors for future diabetes and cardiovascular disease (CVD).

- IFG = FPG 100 – 125 mg/dl
- IGT = 2-h plasma glucose 140 to 199 mg/dl
- HgA1c 5.7 –6.4%

Recommendations for Prediabetic Patients

a) Patients with prediabetes should be referred for intensive behavioral lifestyle intervention program, similar to the Diabetes Prevention Program, with goals including 7% loss of initial body weight and moderate intensity physical activity (such as brisk walking) at least 150 min/week.
b) Consider referring to technology-based resources, self-management education and support programs which may be useful in improving lifestyle modifications to prevent or delay diabetes.
c) Annual monitoring for the development of diabetes in those with prediabetes is suggested.
d) Metformin therapy should be considered for the prevention of type 2 DM, especially in patients with BMI ≥35 kg/m^2, patients aged < 60 yrs, and women with prior gestational DM. Periodic measurement of B12 level is recommended with metformin treatment.
e) Screening for and treatment of risk factors for cardiovascular disease, such as hypertension and dyslipidemia, is recommended.

iv. Gestational diabetes- Universal testing is the policy in the US as early as their first visit as most patients have at least one of the following risk factors. The ADA + ACOU define patients at increased risk of overt diabetes based on:

-BMI > 25 kg/m2 (>23kg/m2 in African Americans) + one or more of the following:

- GDM in previous pregnancy
- A1C > 5.7 or impaired GTT or impaired FG on previous testing
- 1rst degree relative with diabetes
- High risk race/ethnicity (African-American, Latino, Native American, Asian American, Pacific Islander)
- H10 cardiovascular disease
- HTN (>140/90) or an Rx for HTN
- HDL <35mg/dL with triglycerides >250 mg/dL
- Polycystic ovary syndrome
- Physical inactivity
- Other clinical conditions also with insulin resistance (example: severe obesity acanthosis nigricans)
- Previous birth of an infant weighing >400 g (9 lbs)
- Age >40 years old

In the absence of early testing or if early texting is negative, universal screening is performed at 24-28 weeks of gestation. A two-step approach is preferred in the US. Reassess postpartum at 6-12 weeks for diabetes using the non-pregnant criteria.

Detection and diagnosis of Gestational Diabetes Mellitus

Risk assessment for GDM should be undertaken at the first prenatal visit. Women with clinical characteristics consistent with a high risk for GDM (those with marked obesity, personal history of GDM, glycosuria, or a strong family history of diabetes) should undergo glucose testing as soon as possible. An FPG ≥126 mg/dl or a casual plasma glucose ≥200 mg/dl meets the threshold for the diagnosis of diabetes and needs to be confirmed on a subsequent day unless unequivocal symptoms of hyperglycemia are present. High-risk women not found to have GDM at the initial screening and average-risk women should be tested between 24 and 28 weeks of gestation. Testing should follow one of two approaches:

Screening for and diagnosis of GDM

Perform a 75-g OGTT ,with plasma glucose measurement fasting and at 1 and 2h, at 24-48 weeks of gestation in women not previously diagnosed with overt diabetes	
The OGTT should be performed in the morning after an overnight fast of at least 8h	
The diagnosis of GDM is made when any of the following plasma glucose values are exceeded:	
	Fasting: >92 mg/dl (5.1 mmol/l)
	1h: >180 mg/dl (10.0 mmol/l)
	2h: >153 mg/dl (8.5 mmol/l)

- One-step approach: perform a diagnostic 2 hour 75-g OGTT
- Two-step approach: perform an initial screening by measuring the plasma or serum glucose concentration 1 h after a 50-g oral glucose load (glucose challenge test [GCT]) (>135 mg/dL) and perform a diagnostic 100-g OGTT on that subset of women exceeding the glucose threshold value on the GCT.
- Diagnostic criteria for the 100-g OGTT are as follows: ≥95 mg/dl fasting, ≥180 mg/dl at 1 h, ≥155 mg/dl at 2 h, and ≥140 mg/dl at 3 h. Two or more of the plasma glucose values must be met or exceeded for a positive diagnosis. The test should be done in the morning after an overnight fast of 8–14 h.
- Low-risk status requires no glucose testing, but this category is limited to those women meeting all of the following characteristics:
  - Age <25 years.
  - Weight normal before pregnancy.
  - Member of an ethnic group with a low prevalence of GDM.
  - No known diabetes in first-degree relatives.
  - No history of abnormal glucose tolerance.
  - No history of poor obstetric outcome.
  - A1c<5.7

Screening of non-pregnant adults

Generally, people with type 1 diabetes present with acute symptoms of diabetes and markedly elevated blood glucose levels. Type 2 diabetes is frequently not diagnosed until complications appear, and approximately one-third of all people with diabetes may be undiagnosed. Criteria for testing for diabetes in asymptomatic, undiagnosed adults are listed in below. The recommended screening test for non-pregnant adults is the FPG. The OGTT is more sensitive for the diagnosis of diabetes and pre-diabetes, but is impractical and expensive as a screening procedure.

Criteria for testing for diabetes in asymptomatic adult individuals during pregnancy.

1. Testing for diabetes should be considered in all individuals at age 45 years and above.
2. Testing should be considered at a younger age or be carried out more frequently in individuals who are overweight (BMI > 25 kg/m^2) and have additional risk factors:
    - are habitually physically inactive
    - have a first-degree relative with diabetes
    - are members of a high-risk ethnic population (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
    - are hypertensive (>140/90 mmHg)
    - have an HDL cholesterol level < 35 mg/dl and/or a triglyceride level > 250 mg/dl
    - on previous testing, had IGT or IFG
    - have other clinical conditions associated with insulin resistance (e.g. PCOS or acanthosis nigricans)
    - have a history of vascular disease

3. Patients with prediabetes should be tested yearly.

4. Patients with a history of gestational diabetes should be tested at least every 3 years.

5. If results are normal, testing should be repeated at a minimum of 3 year intervals, with consideration of more frequent testing depending on the initial results and risk status.

In the absence of early testing or if early testing is negative, universal screening is performed at 24-28 weeks of gestation.

Two-step approach is preferred in the US.

Evaluation

Complete medical evaluation should be performed to classify the patient, detect the presence or absence of diabetes complications, assist in formulating a management plan, and provide a basis for continuing care. If the diagnosis of diabetes has already been made, the evaluation should review the previous treatment and the past and present degrees of glycemic control. Laboratory tests appropriate to the evaluation of each patient's general medical condition should be performed.

Components of the comprehensive diabetes evaluation

Medical history

- Symptoms, results of laboratory tests, and special examination results related to the diagnosis of diabetes; last dental visit and last dilated eye exam, vaccination history
- Prior A1C records
- Eating patterns, nutritional status, and weight history; growth and development in children and adolescents
- Details of previous treatment programs, including nutrition and diabetes self-management education, attitudes, and health beliefs
- Current treatment of diabetes, including medications, meal plan, and results of glucose monitoring and patients' use of data and technology
- Exercise history and sleep pattern and duration
- Frequency, severity, and cause of acute complications such as ketoacidosis and hypoglycemia; previous hospitalizations with cause and frequency
- Prior or current infections, particularly skin, foot, dental, and genitourinary infections
- Symptoms and treatment of chronic eye, kidney, nerve, genitourinary (including sexual), bladder, and gastrointestinal function (including symptoms of celiac disease in type 1 diabetic patients), heart, peripheral vascular, foot, and cerebrovascular complications associated with diabetes
- Other medications that may affect blood glucose levels
- Risk factors for atherosclerosis: smoking, hypertension, obesity, dyslipidemia, and family history
- History and treatment of other conditions, including hemoglobinopathies, anemia, endocrine and eating disorders
- Assessment for mood disorder and cognitive impairment if needed
- Family history of diabetes and autoimmune disorders
- Lifestyle, cultural, psychosocial, educational, and economic factors that might influence the management of diabetes
- Tobacco, alcohol, and/or controlled substance use
- Contraception and reproductive and sexual history

Physical examination

Complete at every follow up visit:

- Height and weight measurement (and comparison to norms in children and adolescents)
- Sexual maturation staging (during pubertal period)
- Blood pressure, including orthostatic measurements when indicated, and comparison to age-related norms
- Skin examination (for acanthosis nigricans and insulin-injection sites)
- Visual inspection of feet for skin integrity, ulcer, deformity, callous formation

At initial visit and annually:

- Fundoscopic examination
- Thyroid palpation
- Cardiac examination
- Abdominal examination (e.g., for hepatomegaly)
- Evaluation of pulses by palpation and with auscultation
- Comprehensive foot examination, including evaluation of dorsalis pedis pulses, monofilament sensation, vibration sensation)
- Other examination as indicated
- Annual exam by a dentist, even when the patient has no teeth

Laboratory evaluation – Initial visit and Annually except for A1c

- A1C – quarterly, or at least twice annually in patients with stable glycemic control
- Fasting lipid profile, including total cholesterol, HDL cholesterol, triglycerides, and LDL cholesterol
- Test for microalbuminuria in type 1 diabetic patients who have had diabetes for at least 5 years and in all patients with type 2 diabetes; some advocate beginning screening of pubertal children before 5 years of diabetes
- Serum creatinine and eGFR in adults (in children if proteinuria is present)
- Serum potassium levels in patients on ACE inhibitors, ARBs or diuretics
- Thyroid-stimulating hormone (TSH) in all type 1 diabetic patients; in type 2 if clinically indicated
- Liver function tests (as needed for monitoring of medications that may affect values)
- Vitamin B12 if on metformin (initially and annually)
- Electrocardiogram in adults, if clinically indicated

Referrals

- Eye exam, to an optometrist or ophthalmologist (at least once yearly)
- Family planning for women of reproductive age
- Preconception counseling for adolescent girls at puberty to reduce unplanned pregnancy
- Medical Nutrition Therapy program, preferably with registered dietician
- Diabetes educator, if not provided by physician or practice staff
- Behavioral specialist, as indicated
- Foot specialist, as indicated
- Other specialties and services as appropriate
- All type I, pregnant diabetics should be referred to Endocrinologist.

Diabetes Management with Diabetes Care Plan

- **Develop** an individualized Diabetes Care Plan with the patient, reviewing treatment goals, self-monitoring results, medication lists, and barriers to not meeting goals.
- **Update** care plan at least annually and at all visits where diabetes is discussed.
- Care plan development and maintenance should be a **collaborative** process between patient, family, and provider, with patient self-monitoring results recorded in appropriate sections.
- Care plan and communication regarding plan should be **patient-centered**, with consideration of the patient's age, social, cultural, educational and health status, as well as life situation (such as school or work schedule, eating, sleeping and activity patterns).
- Care plan should emphasize diabetes **self-management** and **self-efficacy**, with consideration of and strategies to address barriers to self-care.
- Care plan should be **individualized** to meet patient needs, using resources such as educational handouts, group education including Diabetic Education Classes, individual consultation with CDE, and technology-enabled solutions, such as DSMES programs and apps. Patients who are not meeting diabetic goals will be referred to Diabetic Education Classes, and/or other resources, as appropriate.
- **Lifestyle management** is the foundation of diabetes self-care, and care plan should address healthful eating patterns, physical activity, smoking cessation, psychosocial needs, and if needed, weight management. Medications will often be needed in addition to lifestyle measures to address glycemic, blood pressure or lipid goals. In addition to other psychosocial issues, monitor for and address diabetes distress.

Lifestyle management

Diabetes self-management includes nutrition therapy, with healthful eating patterns, emphasizing nutrient-dense foods in appropriate portion sizes. Increasing physical activity has also been shown to improve diabetes control especially in smoking cessation for smokers.

Goals of medical nutrition therapy are:

1) achieve and maintain body weight goals
2) attain individualized glycemic, blood pressure, and lipid goals

3) to delay and prevent the complications of diabetes

Summary of medical nutrition therapy recommendations

- Refer all diabetic patients (type 1, type 2, and GDM) to individualized MNT program, preferably provided by registered dietitian
- Weight loss goal of >5% benefits overweight or obese adults with type 2 diabetes, as well as those with prediabetes. Consider referral to intervention program.
- A variety of eating patterns are acceptable for the management of type 2 diabetes and prediabetes. Diet may be individualized for patient preferences.
- Increased intake of vegetables, fruits, legumes, whole grains and dairy products higher in fiber and lower in glycemic index are preferred over other sources, such as those containing added sugars, for carbohydrate intake.
- Sugar-sweetened drinks should be avoided by people with diabetes or prediabetes.
- Carbohydrate counting may be of benefit for type 2 diabetes patients receiving a flexible insulin program and for type 1 diabetes patients. Consider CDE and MNT referrals.
- Eating foods rich in long-chain n-3 fatty acids such as fatty fish (EPA and DHA), nuts and seeds (ALA) is recommended; however, evidence does not support n-3 dietary supplements.
- Alcohol consumption may place people with diabetes at risk for hypoglycemia, which should be discussed as part of patient education
- People with diabetes should limit sodium to at least <2,300 mg/day, and further restriction may be indicated for those with diabetes and hypertension.
- Nonnutritive sweeteners may be used within acceptable daily intake levels.

Physical activity recommendations:

- Most adults with type 2 diabetes should engage in 150 min or more of moderate-to-vigorous intensity aerobic activity per week, spread over at least 3 days/week, with no more than 2 consecutive days without activity. Shorter durations (minimum 75 min/week) of vigorous-intensity or interval training may be sufficient for younger and more physically fit individuals.
- Adults with type 2 diabetes should engage in 2–3 sessions/week of resistance exercise on nonconsecutive days.
- All adults, and particularly those with type 2 diabetes, should decrease the amount of time spent in daily sedentary behavior. Consider interrupting prolonged sitting every 30 minutes with physical activity.
- Consider cardiac pre-exercise evaluation for individuals at high cardiovascular risk, although it is not recommended as routine testing for all diabetic patients.
- Certain patients may need to limit intensity or duration of exercise, including those at high cardiovascular risk, patients with proliferative diabetic retinopathy or severe non-proliferative retinopathy. Some patients may be limited in their exercise capacity due to risk of hypoglycemia with insulin therapy or insulin secretagogue therapy, peripheral neuropathy, or other conditions.

Psychosocial care

- Providers should consider assessment for symptoms of diabetes distress, depression, anxiety, disordered eating, and cognitive capacities using patient-appropriate standardized and validated tools at the initial visit, at periodic intervals, and when there is a change in disease, treatment, or life circumstance. Diabetes distress is a common psychological experience in managing a severe, complicated, and demanding chronic disease.
- Including caregivers and family members in this assessment is recommended.
- Consider screening older adults (aged ≥65 years) with diabetes for cognitive impairment and depression.
- Routinely monitor people with diabetes for diabetes distress, particularly when treatment targets are not met and/or at the onset of diabetes complications.
- Refer to mental health specialist as needed.

Weight Management Recommendations

- At each patient encounter, BMI should be calculated and documented in the medical record.
    - For BMI 25-26.8 kg/m^2, recommend diet, physical activity and behavioral therapy (23.0-26.9 kg/m^2 for Asian American patients).
    - Goal should be >5% weight loss, in patients ready to lose weight, and patient may need to achieve 500 to 750 kcal/day energy deficit. High levels of exercise (200 to 300 min/week) may be needed. Refer to CDE and consider referral to MNT and/or medically managed weight loss program for select patients.
    - Initially schedule frequent appointments to focus on diet, physical activity and behavior strategies for the first 6 mos.
    - After 6 to 12 mos, for maintenance of short term weight loss, schedule monthly appointments as needed with weight checks and to reinforce diet and exercise.
    - For BMI ≥ 27 kg/m^2, pharmacotherapy for weight loss may be considered for selected motivated patients.
    - For BMI ≥ 30 kg/m^2, consider referral for evaluation for metabolic surgery for selected motivated patients (≥ 27.5 kg/m^2 for Asian American patients), when hyperglycemia is uncontrolled despite optimal medical therapy.
    - For BMI 35-39.9 kg/m^2 metabolic surgery should be recommended if hyperglycemia is inadequately controlled despite lifestyle and optimal medical therapy (BMI 32.5-37.4 kg/m^2 in Asian Americans).
    - For BMI ≥ 40 kg/m2, metabolic surgery should be recommended for all patients who are appropriate surgical candidates. (BMI ≥ 37.5 kg/m^2 for Asian Americans)

Glycemic control

Glycemic control is fundamental to the management of diabetes. Prospective randomized clinical trials such as the Diabetes Control and Complications Trial (DCCT) and the U.K. Prospective Diabetes Study (UKPDS), which targeted fasting blood glucose, have shown that improved

glycemic control is associated with sustained decreased rates of retinopathy, nephropathy, and neuropathy. In these trials, treatment regimens that reduced average A1C to ~7% (~1% above the upper limits of normal) were associated with fewer long-term microvascular complications; however, intensive control was found to increase the risk of severe hypoglycemia and weight gain.

An A1C test should be performed quarterly in patients whose therapy has changed or who are not meeting treatment goals. It should be checked at least twice a year in those with stable glycemic control.

Recommended glycemic goals for non-pregnant individuals are shown below.

Summary of recommendations for adults with diabetes

Glycemic control	<6.0% +TyI+during pregnancy
AIC	<7.0%
Pre-prandial plasma glucose	90–130 mg/dl
Postprandial plasma glucose	<140 mg/dl
Blood pressure	<140/90 mmHg, in some cases 130/80
Lipids	(Systolic P 125-130 mmg hg)
LDL	<100 mg/dl (<70 if CAD/ASCVD)
Triglycerides	<150 mg/dl
HDL	>40 mg/dl

Monitoring

- Self-Monitoring of Blood Glucose
  - Three times daily for pregnant women or those using basal insulin therapy
  - Three or more times daily for Type 1 diabetics, those on intensive insulin regimens (multiple dose insulin or insulin pump therapy): SMBG prior to meals and snacks, at bedtime, occasionally postprandially, prior to exercise, when hypoglycemic, or prior to critical tasks such as driving
  - Continuous glucose monitoring may be useful in patients who are not meeting glycemic targets in conjunction with intensive insulin regimen
  - Unclear frequency for Type 2 diabetes on non-insulin therapy
- HbA1c
  - Twice annually if treatment goals are met
  - Quarterly for individuals with unmet treatment goals or changes in therapy
  - Point of care testing as needed to guide therapy

- Less stringent A1C goals (such as <8%) may be appropriate for certain patients, such as the elderly, those with a history of severe hypoglycemia, those with significant comorbid conditions, or other factors preventing optimal monitoring or treatment

Pharmacologic therapy for Glycemic Control Guidelines

Type 1 Diabetes

- Most people with type 1 diabetes should be treated with multiple daily injections of prandial insulin and basal insulin or continuous subcutaneous insulin infusion.
- Most individuals with type 1 diabetes should use rapid-acting insulin analogs to reduce hypoglycemia risk.
- Pancreas and islet transplantation should be reserved for patients with type 1 diabetes, undergoing simultaneous renal transplantation, or following renal transplantation, or in those with recurrent keto acidosis or severe hypoglycemia despite intensive glycemic management.

Type 2 Diabetes

- Metformin, if not contraindicated and if tolerated, is the preferred initial pharmacologic agent for the treatment of type 2 diabetes. Monitor vitamin B12 levels periodically with metformin use.
- In patients without atherosclerotic cardiovascular disease, if monotherapy or dual therapy does not achieve or maintain the A1C goal over 3 months, add an additional antihyperglycemic agent based on drug-specific and patient factors.
- In patients with type 2 diabetes and established atherosclerotic cardiovascular disease, antihyperglycemic therapy should begin with lifestyle management and metformin and subsequently incorporate an agent proven to reduce major adverse cardiovascular events and cardiovascular mortality (currently empagliflozin and liraglutide), after considering drug-specific and patient factors.
- For patients with type 2 diabetes who are not achieving glycemic goals, drug intensification, including consideration of insulin therapy, should not be delayed.
- Metformin should be continued when used in combination with other agents, including insulin, if not contraindicated and if tolerated.

CVD: Management of Risk Factors and Screening for Coronary Artery Disease

CVD is the major cause of mortality for persons with diabetes. Type 2 diabetes is an independent risk factor for macrovascular disease, and its common coexisting conditions (e.g., hypertension and dyslipidemia) are also risk factors. Studies have shown the efficacy of reducing cardiovascular risk factors in preventing or slowing CVD.

A. Blood Pressure Control

Recommendations

Screening and Diagnosis

- Blood pressure should be measured at every routine diabetes visit. Patients found to have systolic blood pressure ≥140 or diastolic blood pressure ≥90 mmHg should have blood pressure confirmed on a separate day.

Goals

- Most patients with diabetes should be treated to a systolic blood pressure <140 mmHg.
- Most patients with diabetes should be treated to a diastolic blood pressure <90 mmHg.
- Lower systolic and diastolic blood pressure goals such as 130/80 mmHg may be beneficial in patients with higher risk for cardiovascular disease.
- Patients with prehypertension (blood pressure >120/80) should implement lifestyle interventions and monitoring of blood pressure.

Treatment

- All patient with hypertension and diabetes should monitor their blood pressure at home.
- Patients who have mildly elevated blood pressure >120/80 should be recommended to lose weight if overweight or obese, to reduce sodium and increase potassium intake (DASH style diet), to moderate alcohol intake, and to increase physical activity.
- Patients with hypertension (systolic blood pressure ≥140 or diastolic blood pressure ≥90 mmHg) should receive drug therapy in addition to lifestyle and behavioral therapy.
- Initial drug therapy for those with a blood pressure >140/90 mmHg should be with a drug class demonstrated to reduce CVD events in patients with diabetes (ACE inhibitors, ARBs, thiazide-like diuretics, and dihydropyridine calcium channel blockers).
- Patients with blood pressure ≥ 160/100 mmHg are recommended to receive initial therapy with 2 antihypertensive agents.
- Multiple drug therapy (two or more agents at proper doses) is generally required to achieve blood pressure targets. ACE inhibitors, ARBs and direct renin inhibitors are not recommended to be used in combination with each other.
- All patients with diabetes and hypertension who have albuminuria should be treated with a regimen that includes either an ACE inhibitor or ARB. If one class is not tolerated, the other should be substituted.
- If ACE inhibitors, ARBs, or diuretics are used, monitor renal function and serum potassium levels.
- In patients who are not meeting blood pressure targets with 3 classes of antihypertensives (including a diuretic), the addition of a mineralocorticoid receptor antagonist should be considered.
- In elderly hypertensive patients, blood pressure should be lowered gradually to avoid complications, and higher blood pressure target may be appropriate.
- Patients not achieving target blood pressure despite multiple drug therapy should be referred to a physician experienced in the care of patients with hypertension.
- Pregnant patients with diabetes and/or hypertension should be referred to high risk obstetrics for management.

B. Lipid Management - Dyslipidemia

Patients with type 2 diabetes have an increased prevalence of lipid abnormalities that contributes to higher rates of CVD. Lipid management aimed at lowering LDL cholesterol, raising HDL cholesterol, and lowering triglycerides has been shown to reduce macrovascular disease and mortality in patients with type 2 diabetes, particularly those who have had prior cardiovascular events.

Recommendations

Screening and Monitoring

- In adult patients, test for lipid disorders at least annually and more often if needed to achieve goals. In adults with low-risk lipid values (LDL <100 mg/dl, HDL >50 mg/dl, and triglycerides <150 mg/dl), repeat lipid assessments every 2 years.
- Obtain a lipid profile before and 4 to 12 weeks after starting or changing dose of statin or other lipid-lowering therapy, and annually thereafter.

Treatment Recommendations and Goals

- Lifestyle dietary modification focusing with reduction of saturated fat, *trans* fat, and cholesterol intake, and on increasing plant stanols/sterols, n-3 fatty acids, and viscous fiber (such as oats, legumes, and citrus) is recommended. Additional lifestyle modifications such as weight loss, increased physical activity, and smoking cessation, are also recommended.
- Patients who do not achieve lipid goals with lifestyle modifications require pharmacological therapy.
- Lower LDL cholesterol to <70 mg/dl as the primary goal of therapy for adults.
- Lowering LDL cholesterol with a statin is associated with a reduction in cardiovascular events. Patients who do not tolerate the intended intensity of statin should receive the maximally tolerated dose.
- Consider the addition of Ezetimibe to a statin in patients not meeting lipid goals.
- Adjunctive therapy with PCSK9 inhibitor may be considered in select patients who are receiving maximally tolerated dose of statin and are not meeting LDL cholesterol goal.
- Intensify lifestyle changes and optimize glycemic control in order to lower triglycerides to <150 mg/dl and raise HDL cholesterol to >40 mg/dl. For women, an HDL goal 10 mg/dl higher may be appropriate.
- In patients with a fasting Tg > 500 mg/dl, evaluate for secondary causes and consider medical therapy to reduce pancreatitis risk.

Recommendations for Statin and Combination Treatment in People with Diabetes

Age	Risk Factors	Recommended statin intensity*
<40	**None**	**None**
	ASCVD risk factors**	**Consider Moderate**
	ASCVD	**High**
40-75	**None**	**Moderate**
	ASCVD risk factors	**Moderate**
	ASCVD	**High**
>75	**With or w/o ASCVD risk factors**	**Moderate with consideration for risk benefit profile**
	ASCVD	**High**
All adults	**ASCVD and LDL ≥ 70 mg/dl unable to tolerate high dose statin**	**Maximally tolerated statin plus consider ezetimibe**
	Recent ACS and LDL ≥ 50 mg/dl	**Moderate plus ezetimibe**

***In addition to lifestyle therapy.**

****ASCVD risk factors included LDL cholesterol ≥100 mg/dl, high blood pressure. Smoking, overweight and obesity, and family history of premature ASCVD.**

C. Anti-platelet Agents in Diabetes

Aspirin has been recommended as a primary, secondary, and tertiary prevention therapy to prevent cardiovascular events, including stroke and myocardial infarctions, in diabetic and non-diabetic individuals.

Recommendations

- Consider aspirin therapy (75–162 mg/day) as a primary prevention strategy in those with type 1 or type 2 diabetes at increased cardiovascular risk, including men and women aged over 50 with one additional risk factors (family history of CVD, hypertension, smoking, dyslipidemia, albuminuria).
- Use aspirin therapy (75–162 mg/day) as a secondary prevention strategy in those with diabetes with a history of myocardial infarction, vascular bypass procedure, stroke or transient ischemic attack, peripheral vascular disease, claudication, and/or angina.
- Use dual antiplatelet therapy (with low-dose aspirin and a P2Y12 inhibitor) for a year after an acute coronary syndrome, and consider continuing beyond this period.
- Daily aspirin is not recommended for low risk patients including men and women< 50 years without any cardiac risk factors.
- Daily aspirin not recommended for individuals < 21 yrs because of increased risk of Reye's Syndrome.
- In patients with ASCVD and documented aspirin allergy, clopidogrel should be used. In patients with a history of bleeding or patients who cannot tolerate aspirin, clopidogrel may be used.

D. Smoking Cessation

The routine and thorough assessment of tobacco use is important as a means of preventing smoking or encouraging cessation. Special considerations should include assessment of level of nicotine dependence, which is associated with difficulty in quitting and relapse.

Recommendations

- Advise all patients not to smoke.
- Include smoking cessation counseling and other forms of treatment as a routine component of diabetes care.

E. CHD Screening and Treatment

Recommendations

- In patients with ASCVD or increased ASCVD risk, and HTN, an ACE inhibitor or ARB should be used, unless contraindicated. In patients with ASCVD without HTN, ACE inhibitor or ARB should be considered.
- Patients with ASCVD should receive ASA and statin therapy, unless contraindicated.
- Refer patients with signs and symptoms of CVD or with positive noninvasive test for CAD to a cardiologist for further evaluation.
- In patients with Type 2 diabetes and ASCVD, lifestyle management and metformin should be initiated, with addition of empaglifozin or liraglutide if needed for glycemic control, after considering patient and drug-specific factors.
- Metformin may be used in stable CHF with normal renal function but should be avoided in unstable or hospitalized individuals.

- Use caution in prescribing thiazolidinediones in the setting of known congestive heart failure or other heart disease as well as in patients with pre-existing edema or concurrent insulin therapy. Avoid this medication in symptomatic CHF.
- In patients with a prior myocardial infarction, ß-blockers should be continued for at least 2 years. In patients undergoing major surgery, ß-blockers may be considered to reduce mortality.

F. Nephropathy Screening and Treatment

Diabetic nephropathy occurs in 20–40% of patients with diabetes and is the single leading cause of end-stage renal disease (ESRD). Intensive diabetes management with the goal of achieving near normoglycemia has been shown to delay the onset of microalbuminuria and the progression of micro- to macroalbuminuria in patients with type 1 and type 2 diabetes.

Recommendations

General Recommendations

- To reduce the risk and/or slow the progression of nephropathy, optimize glucose control.
- To reduce the risk and/or slow the progression of nephropathy, optimize blood pressure control. Lower blood pressure goal of < 130/80 may be suitable for some patients.

Screening

- Perform an annual test for the presence of microalbuminuria in type 1 diabetic patients with diabetes duration of ≥5 years and in all type 2 diabetic patients, starting at diagnosis, and in all patients with comorbid hypertension.
- Monitor creatinine annually and eGFR to stage CKD

Treatment

- In patients with elevated urinary albumin-to-creatinine ratio (≥300 mg/g creatinine) and/or eGFR <60 mL/min/1.73 m^2 either ACE inhibitors or ARBs should be used for nonpregnant patients.
- In hypertensive patients with mildly elevated urinary albumin-to-creatinine ratio (30-299 mg/g creatinine) either ACE inhibitor or ARB is recommended for nonpregnant patients.
- Monitor serum creatinine and potassium levels periodically when using ACE inhibitor, ARB or diuretics.
- Decrease protein intake to 0.8 – 1 g/kg body weight per day
- In patients with reduced eGFR, dosing adjustment of metformin and other drugs may be required; metformin is contraindicated in patients with eGFR <30ml/min/1.73m^2.
- Promptly refer to nephrologist if stage 4 CKD (eGFR < 30ml/min/1.73$m^{2)}$, if difficult management, if unclear etiology of kidney disease, or if rapidly progressing kidney disease.

G. Diabetic Retinopathy Screening and Treatment

Diabetic retinopathy is a highly specific vascular complication of both type 1 and type 2 diabetes. The prevalence of retinopathy is strongly related to the duration of diabetes. Diabetic retinopathy is estimated to be the most frequent cause of new cases of blindness among adults aged 20–74 years. Intensive diabetes management with the goal of achieving near normoglycemia has been shown in large prospective randomized studies to prevent and/or delay the onset of diabetic retinopathy.

Recommendations

General Recommendations

- Optimal glycemic control can substantially reduce the risk and progression of diabetic retinopathy.
- Optimal blood pressure control and serum lipid control can reduce the risk and progression of diabetic retinopathy.
- Aspirin therapy does not prevent retinopathy or increase the risks of hemorrhage.

Screening

- Adults and adolescents with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within ~~3~~–5 years after the onset of diabetes.
- Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes.
- Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist who is knowledgeable and experienced in diagnosing the presence of diabetic retinopathy and is aware of its management. Less frequent exams (every 2 years) may be considered with the advice of an eye care professional in the setting of a normal eye exam. Examinations will be required more frequently if retinopathy is progressing.
- When planning pregnancy, women with preexisting diabetes should have a comprehensive eye examination and should be counseled on the risk of development and/or progression of diabetic retinopathy. Women with diabetes who become pregnant should have a comprehensive eye examination in the first trimester and close follow-up throughout pregnancy and for 1 year postpartum. This guideline does not apply to women who develop GDM because such individuals are not at increased risk for diabetic retinopathy.

Treatment

- Promptly refer patients with any level of macular edema, severe NPDR, or any PDR to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy.

H. Neuropathy

The diabetic neuropathies are heterogeneous with diverse clinical manifestations. They may be focal or diffuse. Most common among the neuropathies are chronic sensorimotor, DPN, and autonomic neuropathy. Although DPN is a diagnosis of exclusion, complex investigations to exclude other conditions are rarely needed. The early recognition and appropriate management of neuropathy in the patient with diabetes is important for a number of reasons: *1*) nondiabetic neuropathies may be present in patients with diabetes and may be treatable; *2*) a number of treatment options exist for symptomatic diabetic neuropathy; *3*) up to 50% of DPN may be asymptomatic, and patients are at risk of insensate injury to their feet; *4*) autonomic neuropathy may involve every system in the body; and *5*) cardiovascular autonomic neuropathy causes substantial morbidity and mortality.

I. Foot Care

Amputation and foot ulceration are the most common consequences of diabetic neuropathy and major causes of morbidity and disability in people with diabetes. Early recognition and management of independent risk factors can prevent or delay adverse outcomes. The risk of ulcers or amputations is increased in people who have had diabetes >10 years, are male, have poor glucose control, or have cardiovascular, retinal, or renal complications.

Recommendations

- Obtain a history of any prior lower extremity neurovascular conditions or surgeries, including Charcot foot, ulcers, amputation, vascular surgery, as well as risk factors such as cigarette smoking, retinopathy, and renal disease. Assess for symptoms of neuropathy and vascular disease.
- Perform a comprehensive foot examination annually on patients with diabetes (annual exam starting 5 years after diagnosis for Type 1 diabetes). Perform a visual inspection of patients' feet at each routine visit.
- The foot examination can be accomplished in a primary care setting and should include the use of a10-g monofilament,128-Hz tuning fork, palpation including pulses in the legs and feet, and a visual examination.
- Educate all patients, especially those with risk factors, including smoking, or prior lower-extremity complications, about the risk and prevention of foot problems and reinforce self-care behavior.
- The use of specialized therapeutic footwear is recommended for high-risk patients with diabetes, including those with severe neuropathy, foot deformities, or history of amputation.
- Either pregabalin or duloxetine are recommended as initial pharmacologic treatments for neuropathic pain.
- Refer high-risk patients to foot care specialists for ongoing preventive care and life-long surveillance.
- Initial screening for PAD should include a history for claudication and an assessment of the pedal pulses. Consider obtaining an ABI, as many patients with PAD are asymptomatic.
- Refer patients with significant claudication or a positive ABI for further vascular assessment and consider exercise, medications, and surgical options.

J. Preventive Care

Immunization

Influenza and pneumonia are common, preventable infectious diseases associated with high mortality and morbidity in the elderly and in people with chronic diseases.

Recommendations

- Annually provide an influenza vaccine to all diabetic patients 6 months of age or older.
- Provide at least one lifetime pneumococcal vaccine for adults with diabetes. A one-time revaccination is recommended for individuals >64 years of age previously immunized when they were <65 years of age if the vaccine was administered >5 years ago. Other indications for repeat vaccination include nephrotic syndrome, chronic renal disease, and other immuno-compromised states, such as after transplantation.
- 3-dose hepatitis B vaccine is recommended for all unvaccinated adults with diabetes ages 19-59, and may be considered for ages ≥6 60 years.

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17. Lead Screening

Significant exposure to lead is a preventable environmental threat to optimal health and developmental outcomes for young children. An estimated half a million children aged 1 - 5 years have elevated blood lead levels (BLL). In 2012, the CDC revised the guidelines for childhood lead poisoning and reduced the acceptable blood lead level to less than 5 micrograms per deciliter (mcg/dl). This was based on evidence from studies that showed that the effects of lead are irreversible and can occur at levels < 10 mcg/dl. The major source of lead exposure is lead-based paint and lead contaminated dust found in deteriorating buildings. Lead based paints were banned for use in housing in 1978. However, approximately 24 million housing units have deteriorated lead paint and elevated level of lead contaminated dust. Children of all socioeconomic levels can be affected, although children in low-income households who live in older homes are at greatest risk. The highest rates are among African-American and urban children. Other sources of lead include costume jewelry and toys and contaminated foods and water.

The detrimental effect of lead on cognitive functions has been well documented. In general, approximately a half "IQ" point is lost, possibly permanently, for each 1 mcg/dl increase in BLL. Research has also shown an association with lead exposures and problems with attention, aggression, and antisocial and delinquent behaviors.
Fewer than 5% of children are diagnosed as having lead poisoning based on clinical presentation. Gastrointestinal related symptoms include anorexia, nausea, vomiting, abdominal pain and constipation. At very high levels, some children may develop encephalopathy with changes in mental status, ataxia, seizures or coma.

The diagnosis can be suspected if responses to routine questions are affirmative for sources of exposure such as peeling paint in old housing and behaviors such as pica and placing non-food items in the mouth. Ultimately, the diagnosis depends on the results of blood testing.

The goal of screening is to ensure that children at risk of exposure to lead are tested.
A brief community-specific risk assessment questionnaire should be administered during well childcare visits continuing until 6 years of age. If answers indicate risk, BLLs should be measured. All questionnaires should include the following 3 risk assessment questions:

1) Does your child live in or regularly visit a house built before 1950?
2) Does your child live in or regularly visit a house built before 1978 that is being renovated or remodeled?
3) Does your child have a sibling or playmate who has lead poisoning?

It is recommended that a blood lead test be administered to all children at risk at ages 12 & 24 months; children who have not previously been screened should be tested at ages 36-72 months. If children are exposed to lead, BLLs tend to increase during 0 to 2 years and peak at 18-24 months as the toddler gains mobility and practices hand to mouth behavior.

Screening is thus recommended at both ages 1 and 2 years to identify children who need medical and environmental management. Identifying a child with an elevated BLL at age 1 year might prevent additional increases during ages 1-2 years. In addition, a child with a normal BLL at 1

year might have an elevated level by age 2, underscoring the importance of rescreening at age 2 years. Screening is recommended for previously untested children < 6 years to rule out subclinically elevated BLLs during critical stages of development.

The standard to determine BLLs requires a properly collected venous sample. A capillary blood sample may be a practical screening alternative.

Children identified with elevated BLLs should be evaluated and treated in accordance with approved guidelines from the CDC, AAP and DHMH.

Few children will have levels high enough to warrant intensive medical treatment (e.g. chelation therapy). However, many children with elevated BLLs will need follow up services, including more frequent blood lead testing, environmental investigation and case management.

Recommended Follow Up Services According to BLLs

BLL	**/ Action**
<5	Continue to assess for lead exposure every well child visit.
5-14	Obtain a confirmatory venous lead level within **three months**; if still in this range, provide education to decrease lead exposure. Repeat BLL within **three months** until < 5 for 6 months.
15-29	Obtain a confirmatory venous lead level within **one week;** if still in this range, conduct a complete medical history including environmental and nutritional assessment, and physical exam. Provide education to decrease lead exposure. Refer the patient to local health department or provide case management that should include a detailed environmental investigation with lead hazard reduction and appropriate referrals for support services. Repeat BLL at 1-2 month intervals until <5 for 6 months.
30-44	**As above**
45 –69	Obtain a confirmatory venous lead level within **48 hours**; if still in this range, perform a complete medical history and physical exam. Provide educational services. Refer Patient to local health department and case management. Begin chelation therapy in consultation with clinician experienced with lead toxicity therapy. Retest monthly until BLL is<5 for 6 months.
>70	Hospitalize the patient and begin medical treatment immediately in consultation with a clinician experienced with lead toxicity therapy. Obtain a confirmatory BLL **within 24 hours.**

Consult with special care center for follow up.
Environmental health specialists from the health department are essential in providing environmental assessment, lead abatement or alternative housing.
Retest monthly until BLL is < 5 for 6 months.

Low level lead exposure is a causal risk factor for diminished intellectual and academic abilities, higher rates of neurobehavioral disorders such as hyperactivity and attention deficits, and lower birth weight in children. No safe blood lead level has been established and some effects of lead are permanent. Reducing lead exposure from residential lead hazards, contaminated food and water, and other consumer products is an effective way to prevent childhood lead poisoning. Lead poisoning and its sequelae can be prevented by blood lead screening followed, when appropriate, by education, case management, environmental abatement and referrals for social services and medical management as needed. Lead remains an important public health problem and conducting recommended screening and referrals can optimize outcomes.

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18. Obesity Guidelines

Obesity is an epidemic in the United States:

- Two-thirds of the population is classified as overweight or obese
- Poor diet and physical inactivity are the two greatest risk factors
- Rates of obesity are highest among African Americans and less economically affluent, less educated populations
- Health consequences of obesity are myriad, including but not limited to:
  - Diabetes mellitus
  - Hypertension
  - Dyslipidemia
  - Myocardial infarction
  - Cerebrovascular accidents
  - Fertility problems
  - Liver disease
  - Pulmonary disease
- Mortality increases significantly in overweight and obese populations and directly correlates with the degree of obesity

Classification:

Adults: Obesity is classified according to body mass index (BMI), which is calculated by taking a person's weight in kilograms and dividing it by the square of the person's height in meters (kg/m^2). BMI can also be measured by taking the person's height in inches squared divided into the person's weight in pounds multiplied by 703. Obesity is categorized as follows:

Classification	BMI	Disease Risk*
Normal	18.5 – 24.9	Normal
Overweight	25 – 29.9	Increased
Obesity		
• Class I	30 – 34.9	High
• Class II	35 – 39.9	Very High
• Class III (morbid obesity)	40+	Extremely High

* for type 2 diabetes, high blood pressure, and coronary vascular disease

Children: Obesity is classified slightly differently for children two years of age and older. BMI is first calculated and then plotted on sex-specific BMI-for-age growth charts to give a BMI percentile. BMI percentiles take into account the fact that percentage of body fat changes with age and the fact that body fat content differs between boys and girls. Obesity is then classified according to BMI percentile, as below:

Classification	BMI Percentile Range
Normal	5^{th} to 85^{th} percentile
Overweight	85^{th} to just under 95^{th} percentile
Obese	95^{th} percentile and above

Screening:
Both the National Institutes of Health and the U.S. Preventive Services Task Force (USPSTF) recommend screening for obesity at regular intervals.

Diagnosis:
At the initial clinical visit, weight and height should be measured and BMI calculated (online free BMI calculator available at http://www.nhlbisupport.com/bmi/). At each subsequent office visit, weight should be taken and BMI re-calculated and tracked on the appropriate form. Though a patient may not appear to be overweight or obese, BMI should be calculated for every patient at each visit.

A full history and physical examination should be undertaken and the patient should be asked questions regarding:

- Diet (types of foods, frequency of meals, snacking, eating out, access to healthy foods, portion sizes, cultural traditions, etc.)
- Exercise
- Complications noted from obesity
- Family history of obesity, diabetes, and cardiovascular disease
- Previous weight loss efforts
- Presence of eating disorder symptoms (such as binging, purging, etc.)
- Symptoms of possible secondary causes of obesity (such as oral contraceptive use, pregnancy, smoking cessation, medications, and symptoms consistent with endocrinopathies)

Diagnostic Evaluation:

I. Screening for:
   - Diabetes
   - Dyslipidemia
   - Liver dysfunction

II. Further diagnostic work up should be patient-specific, based on history and physical examinations:
   - Signs/symptoms of hypothyroidism: check TSH and free T4
   - Signs/symptoms of Cushing's syndrome: check 24-hour urinary free cortisol level

Physical examination:

- Full vitals
- Waist circumference (optional)
- Full examination
- Subsequent office visits: full set of vitals and focused exam based on co-morbidities

Management:

Many patients do not know or understand that they are considered overweight or obese, but increased awareness has been shown to lead to more attempts at weight loss and the USPSTF recommends offering intensive counseling and behavioral interventions to obese patients. Physicians should:

- Alert patients to their overweight or obese status
- Counsel regarding food choices:
  - Eliminate non-nutritive calories like fried foods, fast foods, added sugars, sodium, and refined grains
  - Emphasize eating nutrient-dense foods such as fruits, vegetables, whole grains, legumes (beans, peas, nuts), low-fat milk products, and lean meats
- Discussions on healthy eating should include any additional family members when possible, as meal preparation may not be solely in the hands of the patient
- Advise patients to start an exercise regimen that they find sustainable (and that requires little to no equipment) and that incorporates both aerobic and anaerobic exercise; goal: 30-60 minutes of exercise approximately five times per week
- Offer educational handouts at each visit: brochures on exercise, healthy eating, and weight control are available in each physician office
- Refer all obese or overweight patients to Jai Medical Center's Obesity/Weight Loss class and document this in the chart. In the Obesity/Weight Loss Class, patients write individualized diet, exercise, and/or weight loss goals with plans for attaining these goals and they are given tools to assess their progress and better understand the barriers they face if treatment goals are not attained
- Develop an individualized Weight Management Care Plan with the patient annually, reviewing treatment goals, self-monitoring results, medication lists, and barriers to not meeting goals at each visit; one copy of the Weight Management Care Plan should go home with the patient and one copy should be retained in the chart behind the Wellness Plan
- Instruct the patient to bring the Weight Management Care Plan back with them to subsequent office visits with self-monitoring results recorded in the appropriate section
- Start a Weight Management Flow Sheet to record in a longitudinal fashion the patient's height, weight, and weight loss goals; track weight management information during each visit where the physician and patient discuss weight management issues and goals

Other Treatments

- Several commercial weight loss programs are available; however, if a patient chooses to participate in one, encourage them to choose one with a maintenance phase of at least two years after the end of the program to be successful
- Many weight loss programs and fad diets undertake weight loss in a manner that is neither healthy nor lasting
- Weight loss goals should be reasonable and sustainable and should focus on enduring lifestyle changes, not on quick fixes; a maximum of 0.9 – 1.5 kg/week (or 2-3 pounds/week) of weight loss is usually medically safe; however, weight loss goals should be individualized, taking into consideration the patient's co-morbidities, family life, and cultural background
- Weight loss should be closely monitored by a physician, as sudden loss of large amounts of weight can lead to complications including cardiac arrhythmias, electrolyte derangements, hyperuricemia, and possibly even the development of eating disorders
- Few medications for weight loss are approved by the FDA: none of the medications available have proven long-term effectiveness; several weight loss medications have been pulled off of the market; physicians should use caution if considering prescribing weight loss medications
- Bariatric surgery is the only therapeutic modality which has been associated with sustained weight loss in morbidly obese patients; consider referring patients with a BMI of >40 or a BMI 35- 40 with significant co-morbidities to a bariatric surgeon for further consideration

Follow Up

- Assess progress towards goals at each appropriate follow-up visit and review and update the Weight Management Care Plan as needed
- Complete the Weight Management Flow Sheet during each visit where the physician and patient discuss weight management issues and goals
- If the patient is achieving good outcomes, document this in the continuation notes
- Encourage patients to visit their PCP at least every 3 months and to complete an annual history and physical

Resources

- Rethink Your Drink Brochure: http://www.cdc.gov/nccdphp/dnpa/nutrition/pdf/rethink_your_drink.pdf
- Food Diary: http://www.cdc.gov/healthyweight/pdf/food_diary_cdc.pdf
- Physical Activity Diary: http://www.cdc.gov/healthyweight/pdf/physical_activity_diary_cdc.pdf
- Healthy Choices in the Workplace: http://www.cdc.gov/obesity/downloads/tips-for-offering-healthier-options-and-pa-at-workplace.pdf

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NEWS & TERRORISM

COMMUNICATING IN A CRISIS

A fact sheet from the National Academies and the U.S. Department of Homeland Security

"Communication before, during and after a biological attack will be a critical element in effectively responding to the crisis and helping people to protect themselves and recover."

A Journalist's Guide to Covering Bioterrorism *(Radio and Television News Director's Foundation, 2004)*

BIOLOGICAL ATTACK

HUMAN PATHOGENS, BIOTOXINS, AND AGRICULTURAL THREATS

WHAT IS IT?

A **biological attack** is the intentional release of a pathogen (disease-causing agent) or biotoxin (poisonous substance produced by a living organism) against humans, plants, or animals. An attack against people could be used to cause illness, death, fear, societal disruption, and economic damage. An attack on agricultural plants and animals would primarily cause economic damage, loss of confidence in the food supply, and possible loss of life. It is useful to distinguish between two kinds of biological agents:

- Transmissible agents that spread from person to person (e.g., smallpox, Ebola) or animal to animal (e.g., foot and mouth disease).
- Agents that may cause adverse effects in exposed individuals but that do not make those individuals contagious to others (e.g., anthrax, botulinum toxin).

Availability of Agents

The Centers for Disease Control and Prevention (CDC) lists the biothreat agents considered to pose the highest threat (see Table 1). Once obtained, agents must be cultured or grown in quantity and then processed for use in an attack ("weaponized"). Agents can be:

- **Isolated from sources in nature.** The threat agents in Table 1 are either biotoxins or agents that cause zoonotic diseases (that occur in wildlife and are transmissible to humans)—except for smallpox, which is solely a human disease and has been eradicated from nature.
- **Acquired from laboratories or bioweapons stockpile.** Smallpox virus is officially studied in only two laboratories in the world. Anthrax is widely studied in labs. Hemorrhagic fever viruses are studied only in limited high-security locations. Most high threat agents had been studied and stockpiled in bioweapons programs outside the United States until as recently as the 1990s.
- **Synthesized or genetically manipulated in a laboratory.** This would require expertise and access to advanced technology.

How Biological Agents Could Be Disseminated

For an attack on people, biological agents could be disseminated in one or more of the following ways:

- **Aerosol dissemination** is the dispersal of an agent in air from sprayers or other devices. The agent must be cultured and processed to the proper size to maximize human infections, while maintaining the agent's stability and pathogenicity (ability to produce illness). An aerosol attack might take place outdoors in a populated area or

Table 1. Diseases/Agents Listed by the CDC as Potential Bioterror Threats (as of March 2005). The U.S. Department of Agriculture maintains lists of animal and plant agents of concern.

CATEGORY A: Easily disseminated and/or contagious; high mortality rates; might disrupt society; requires special action for public health preparedness.

Bacteria (single-celled organisms):
- Anthrax *(Bacillus anthracis)*
- Plague *(Yersinia pestis)*
- Tularemia *(Francisella tularensis)*

Viruses (DNA or RNA requiring other host cells to replicate):
- Smallpox (Variola major virus)
- Viral Hemorrhagic Fevers: Ebola, Marburg, Lassa, Machupo *(various families of viruses)*

Biotoxins (poisonous substances produced by living organisms):
- Botulism *(Clostridium botulinum toxin)*

CATEGORY B: Moderately easy to disseminate; moderate illness rates, low mortality; requires enhanced diagnostic capacity, surveillance.

Bacteria:
- Brucellosis *(Brucella species)*
- Glanders *(Burkholderia mallei)*
- Melioidosis *(Burkholderia pseudomallei)*
- Psittacosis *(Chlamydia psittaci)*
- Food safety threats *(e.g., Salmonella species, Escherichia coli O157:H7, Shigella)*
- Water safety threats *(e.g., Vibrio cholerae, Cryptosporidium parvum)*

Viruses:
- Viral encephalitis (Alphaviruses)

Rickettsia (micro-organisms that live in cells):
- Q fever *(Coxiella burnetii)*
- Typhus fever *(Rickettsia prowazekii)*

Biotoxins:
- Epsilon toxin of Clostridium perfringens
- Ricin toxin from castor beans
- Staphylococcal enterotoxin B

CATEGORY C: Emerging infectious diseases that could be a future threat. (not all-inclusive)

Viruses:
- Examples are Nipah virus and Hantavirus

indoors, e.g., in the ventilation system of a building, in the subway, on planes. It takes expertise to process biological agents to *maximize* the effect of aerosol dissemination, but even relatively crude devices could have an impact.

- **Food or water,** especially ready-to-eat food (vegetables, salad bars) could be intentionally contaminated with pathogens or toxins. The water supply is less vulnerable because dilution, filtration, and the addition of chlorine can kill most disease-causing organisms.
- **Human carriers** could spread transmissible agents by coughing, through body fluids, or by contaminating surfaces. Most agents would make people ill or incapacitated before they become highly contagious, thereby reducing transmission of the disease.
- **Infected animals** can cause people to become ill through contact with the animals or contaminated animal products.
- **Insects** naturally spread some agents such as plague bacteria (vector borne illnesses) and potentially could be used in an attack.
- **Physically distributed** through the U.S. mail or other means.

For an agricultural attack:

- **A point introduction** of an infected plant or animal or its fluids could spread disease through the rest of the crop or livestock. Agricultural biothreat agents (e.g., foot and mouth disease, avian influenza, soy bean rust, and karnal bunt of wheat) do not have to be aerosolized to be effectively disseminated.

Historical Perspective on Biological Attack

- In 2001, the anthrax attacks through the U.S. mail infected 11 people with inhalational anthrax, of which five died. An additional 11 people were infected with cutaneous (skin) anthrax, of which there were no fatalities.
- In the 1990s, the cult Aum Shinrikyo failed in attempts to release anthrax and botulinum toxin in Tokyo but did succeed in a chemical attack with Sarin nerve agent.
- In 1984, the cult followers of Baghwan Shree Rajneesh sickened 751 people in Oregon by placing salmonella bacteria in salad bars in 10 restaurants to keep people from voting in an election.
- In World War II, Unit 731 in Japanese-occupied Manchuria dropped plague-infected fleas in China, allegedly resulting in more than 50,000 deaths.
- In World War I, German agents successfully infected Allied livestock with anthrax and glanders.
- In the 1340s, Europeans threw plague-infected cadavers over city walls to infect those within.

Laws and Treaties Governing Biological Weapons

- The Geneva Convention of 1925 was the first international agreement to address chemical and biological weapons. It prohibits "bacteriological methods of warfare," but did not outlaw the development of such weapons.
- The Biological and Toxins Weapons Convention (BWC) of 1972 is the first arms control treaty to outlaw an entire class of weapons and forbids States from developing, producing, stockpiling, or retaining biological weapons or assisting other States in developing these weapons systems.
- The Australia Group is a loose association of nations that agrees not to export tools and technologies, including pathogens, that have "dual uses"—that is, they can be used for both legitimate and nefarious purposes.

Table 2. Onset, Health Impacts, and Treatments for Some Agents of Concern

Disease (agent)	Incubation period*	Symptoms
HIGH THREAT AGENTS (CATEGORY A)		
Anthrax *(Bacillus anthracis)* (inhalational)	typically 1–6 days, but up to 42	Fever, cough, profound sweats malaise, fatigue, myalgiaus
Plague *(Yersinia pestis)*	1–7 days (usually 2–3 days)	Fever, cough, shortness of breath, sore lymph nodes
Tularemia *(Francisella tularensis)*	1–21 days (avg 3–6)	Fever, cough, pneumonia, headache
Marburg (Viral hemorrhagic fever)	4–21 days	Sudden onset, fever, headache, followed by vomiting and diarrhea, rash, generalized bleeding in severe cases
Ebola (Viral hemorrhagic fever)	4–21 days	Sudden onset, fever, headache, followed by vomiting and diarrhea, rash, generalized bleeding in severe cases
Smallpox (Variola major virus)	7–17 days (avg 12)	Fever, aches, after 2–4 days rash appears
Botulism *(Clostridium botulinum* toxin)	12 hours–5 days	Muscle paralyzing illness
LOWER THREAT AGENTS (SELECTED CATEGORY B AGENTS)		
Cholera (*Vibrio cholerae*)	4 hours–5 days (usually 2–3 days)	Sudden onset of voluminous watery diarrhea, vomiting, cramps, dehydration
Glanders *(Burkholderia mallei)*	1–14 days via aerosol	Pneumonia with or without blood poisoning, ulcers in nose, mouth, throat and lungs
Q fever *(Coxiella burnetii)*	7–41 days	Flu-like illness that can lead to pneumonia and hepatitis
Encephalitis (Alphaviruses)	2–6 days	Fever, aches, pain behind the eye, nausea, vomiting
Ricin *(Ricinus communis)*	18–24 hours	Can shut down organ function

** Incubation periods listed are for naturally occurring outbreaks, which could differ for agents used as weapons. Data for incubation p*

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IMPACT FOLLOWING THE RELEASE OF A PATHOGEN

Detection of a Biological Attack

Unlike a chemical or nuclear attack, a biological attack may go undetected for hours, days, or potentially weeks (depending on the agent) until people, animals, or plants show symptoms of disease. If there are no immediate signs of the attack as with the anthrax letters, a biological attack will probably first be detected by local health care workers observing a pattern of unusual illness or by early warning monitoring systems that detect airborne pathogens. Evidence of an attack may appear in animals before humans.

The Area Affected

For an aerosol release, the area affected would depend on the quantity of agent released, whether the release is indoors or outdoors, and weather conditions. Agents released outdoors would disperse roughly in the direction of the prevailing wind and could degrade with sunlight and by drying out from environmental exposure. Agents released indoors could initially have a higher concentration. Sometimes agents can be re-aerosolized by machinery, foot traffic, or other means.

Finding the Cause and Source of Illness

There may be uncertainties about crucial facts such as the exact location or extent of the initial release, the type of biological agent used, and likelihood of additional releases. Laboratory scientists will work quickly to identify the specific agent. Epidemiologists will attempt to trace the path of infections back toward a single person, vector (insect or animal), vehicle (food or water), or other point of origin. Attribution of a biological attack is typically much more difficult than attribution of a conventional terrorist attack.

Spread (person to person)	**Lethality if untreated**	**Persistence of Organism**	**Vaccine Status** (as of March 2005)	**Medical Treatment**
No (only skin form spreads)	High (if inhaled) viable in soil > 40 yrs	Very stable spores	Licensed	Antibiotics
Moderate	High unless treated within 12–24 hours (pneumonic)	For up to 1 year in soil; 270 days in live tissue	Not current	Antibiotics
No	Moderate	For months in moist soil or other media	Not current	Antibiotics
Via fluids	>25% lethal	Relatively unstable	None	Supportive treatment only
Via fluids	50–80% lethal	Relatively unstable	Investigational	Supportive treatment only
Moderate	High to moderate ≥30% lethal	Very stable	Licensed	Supportive
No	High without respiratory support	Stable for weeks in nonmoving food/water	Licensed (availability uncertain)	Antitoxin if administered quickly
Rare, although spreads rapidly via untreated water	Low with treatment, high without	Unstable in aerosols & fresh water, stable in salt water	Investigational	Antibiotics
No	Death in 7–10 days in blood poisoning form	Very stable	None	Antibiotics
No	Very low	For months on wood and sand	Not licensed in U.S.	Antibiotics
Low	Low	Relatively unstable	None	Supportive treatment
No	High (injected)	Stable supportive treatment	Investigational	No antidote;

period, lethality, and persistency from U.S. Army Medical Research Institute of Infectious Diseases Blue Book, August 2004.

WHAT IS THE DANGER?

Impact on Human Health

Biothreat agents have the potiential to produce a life-threatening illness. Biotoxins are essentially poisons that can be fatal at high enough doses. Table 2 lists health impacts and medical treatments for the Category A and some Category B agents. Even a small amount of some biothreat agents released in air could result in significant loss of life, depending on a number of factors that include the:

- Infectivity of the agent (how many particles are needed to cause illness).
- Lethality of the agent.
- Length of time it takes to detect and treat those who are exposed or have become ill.

Dose Response in Humans

The exact infectious dose (the number or organisms needed to make one sick) of most biological agents is unknown; approximate doses are extrapolated from animal studies. Whether a person becomes ill after exposure to a biological agent depends on a number of factors including:

- Type and amount of agent taken into the body.
- Duration of exposure.
- Route of exposure (inhalation, ingestion, insect bite).
- "Host" factors (e.g., age, immune status, other illnesses of the person exposed).

Differences in Intentional vs. Natural Outbreaks of Disease

Naturally occurring outbreaks of category A agents have become rare because of improved living standards, hygiene, and health services in developed nations. For example, human bubonic plague,which was transmitted by rats and fleas to humans in past centuries resulting in large losses of life, has virtually been wiped out. However, agents used in an aerosol attack may act differently than naturally occurring outbreaks and could produce a form of the disease with a shorter time of onset of illness, making timely diagnosis, treatment, and containment more difficult.

Spread of Diseases

Some transmissible (contagious) diseases can spread through respiratory droplets from coughing and sneezing or when a person comes in contact with a surface harboring a virus or bacteria and then touches their mouth or nose. The viral hemorrhagic fevers and cholera are spread by direct contact with body fluids or feces. People infected with contagious diseases may widely disseminate the disease by travel.

Psychological Impact

Psychological responses following a bioterrorism event may include anger, fear, and social isolation. Following the 2001 anthrax attacks, thousands of people who thought they were infected sought treatment. Trying to distinguish those who haven't been infected could complicate medical centers' ability to treat those who have been exposed and infected, especially when diagnoses are unclear.

WHAT SHOULD PEOPLE DO TO PROTECT THEMSELVES?

Practical Steps

During a declared biological emergency:

1. People in the group or area that authorities have linked to exposure who have symptoms that match those described should seek emergency medical attention.

Infectious Is Different From Contagious

The terms "infectious" and "contagious" are often confused. Infectious refers to the number of particles (spores or organisms) needed to infect an individual. The fewer number of particles needed, the more in-fectious the agent. Agents are contagious if they spread from person to person. Some agents that are highly infectious, such as Tularemia and Q fever, are not contagious.

2. Use common sense, practice good hygiene and cleanliness to avoid spreading germs.

People who are potentially exposed should:

1. Follow instructions of health care providers and other public health officials.
2. Expect to receive medical evaluation and treatment. Be prepared for long lines. If the disease is contagious, persons exposed may be quarantined.

If people become aware of a suspicious substance nearby, they should:

1. Quickly get away.
2. Cover their mouths and noses with layers of fabric that can filter the air but still allow breathing.
3. Wash with soap and water.
4. Contact authorities.
5. Watch TV, listen to the radio, or check the Internet for official news and information including the signs and symptoms of the disease, if medications or vaccinations are being distributed, and where to seek medical attention if they become sick.
6. Seek emergency medical attention if they become sick.

Medical Treatment

Table 2 lists general medical treatments for several biothreat agents. In general, bacterial illnesses are treated with antibiotics, and viral illnesses are treated with supportive care, although there are a few specific medications to treat viral infections. Biotoxins are treated with antidotes or antitoxins, if available. Vaccines can prevent or mitigate the effects of a disease. The smallpox vaccine may provide protection even if given 1–4 days after exposure, and the anthrax vaccine can be given after inhalation exposure if accompanied by treatment with antibiotics for a number of weeks.

Controlling the Spread of Contagious Diseases

Methods to control contagious disease include isolation, quarantine, barrier methods (gloves, filter masks, eye protection), and hand washing. Rapid identification of potentially infected persons increases the effectiveness of these methods.

WHAT ARE THE LONG-TERM CONSEQUENCES?

Monitoring and Clean-up

After a biological agent has been identified, officials will take steps to characterize how long the agent will persist. Clean-up within buildings may entail the use of gas or liquid decontaminants to kill the agent. For example, chlorine dioxide gas was released through ventilation systems of buildings contaminated with anthrax. In some cases, multiple rounds of decontamination may be necessary. Decisions regarding how much clean-up is necessary will depend on:

- The amount of agent released.
- How far the agent has spread.
- How the space will be used following clean-up.

Long-term Health Consequences Following Exposure

The long-term health consequences for those who survive exposure to biological attack agents are unknown. A long-term medical surveillance program would likely be established to monitor potential health effects of those exposed.

Economic Impact of an Agricultural Attack

Once detected, an act of agricultural bioterrorism may quickly halt the movement and export of livestock or the affected crop, resulting in potentially severe economic consequences for producers, shippers, and consumers. It may also disrupt normal travel and commerce.

ADDITIONAL INFORMATION

Centers for Disease Control and Prevention—**http://www.bt.cdc.gov**

Infectious Disease Society of America—**http://www.idsociety.org**

National Institute of Allergy and Infectious Disease—**http://www.niaid.nih.gov/biodefense/**

U.S. Army Medical Research Institute of Infectious Diseases—**http://www.usamriid.army.mil**

U.S. Department of Health and Human Services —**http://www.hhs.gov/emergency**

U.S. Department of Homeland Security—**http://dhs.gov/dhspublic** • **http://www.ready.gov**

This report brief was prepared by the National Academy of Engineering and National Research Council of the National Academies in cooperation with the Department of Homeland Security. For more information or referrals to subject-matter experts, contact Randy Atkins at 202-334 1508, atkins@nae.edu, or visit www.nae.edu/factsheets. *Making the Nation Safer*, *Tracking the Atmospheric Dispersion of Hazardous Materials Releases* and other National Research Council reports related to this topic are available from the National Academies Press, 500 Fifth Street, NW, Washington, DC 20001; 800-624-6242; www.nap.edu.

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Homeland Security

Attachment I:
Behavioral Health Carve-Out
Diagnosis Codes

Substance Use Disorder ICD-10 Codes

Maryland Department of Health

For dates of service on or after October 1, 2015:

Code	Diagnosis Description	Revision Date
F1010	Alcohol abuse, uncomplicated	
F1011	Alcohol abuse, in remission	10/1/17
F10120	Alcohol abuse with intoxication, uncomplicated	
F10121	Alcohol abuse with intoxication delirium	
F10129	Alcohol abuse with intoxication, unspecified	
F10130	Alcohol abuse with withdrawal, uncomplicated	10/1/20
F10131	Alcohol abuse with withdrawal delirium	10/1/20
F10132	Alcohol abuse with withdrawal with perceptual disturbance	10/1/20
F10139	Alcohol abuse with withdrawal, unspecified	10/1/20
F1014	Alcohol abuse with alcohol-induced mood disorder	
F10150	Alcohol abuse with alcohol-induce psychotic disorder with delusions	
F10151	Alcohol abuse with alcohol-induce psychotic disorder with hallucinations	
F10159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified	
F10180	Alcohol abuse with alcohol-induced anxiety disorder	
F10181	Alcohol abuse with alcohol-induced sexual dysfunction	
F10182	Alcohol abuse with alcohol-induced sleep disorder	
F10188	Alcohol abuse with other alcohol-induced disorder	
F1019	Alcohol abuse with unspecified alcohol-induced disorder	
F1020	Alcohol dependence, uncomplicated	
F1021	Alcohol dependence, in remission	
F10220	Alcohol dependence with intoxication, uncomplicated	
F10221	Alcohol dependence with intoxication delirium	
F10229	Alcohol dependence with intoxication, unspecified	
F10230	Alcohol dependence with withdrawal, uncomplicated	
F10231	Alcohol dependence with withdrawal delirium	
F10232	Alcohol dependence with withdrawal with perceptual disturbance	
F10239	Alcohol dependence with withdrawal, unspecified	
F1024	Alcohol dependence with alcohol-induced mood disorder	
F10250	Alcohol dependence with alcohol-induce psychotic disorder with delusions	
F10251	Alcohol dependence with alcohol-induce psychotic disorder with hallucinations	

F10259	Alcohol dependence with alcohol-induce psychotic disorder, unspecified	
F10280	Alcohol dependence with alcohol-induced anxiety disorder	
F10281	Alcohol dependence with alcohol-induced sexual dysfunction	
F10282	Alcohol dependence with alcohol-induced sleep disorder	
F10288	Alcohol dependence with other alcohol-induced disorder	
F1029	Alcohol dependence with unspecified alcohol-induced disorder	
F10920	Alcohol use, unspecified with intoxication, uncomplicated	
F10921	Alcohol use, unspecified with intoxication delirium	
F10929	Alcohol use, unspecified with intoxication, unspecified	
F10930	Alcohol use, unspecified with withdrawal, uncomplicated	10/1/20
F10931	Alcohol use, unspecified with withdrawal delirium	10/1/20
F10932	Alcohol use, unspecified with withdrawal with perceptual disturbance	10/1/20
F10939	Alcohol use, unspecified with withdrawal, unspecified	10/1/20
F1094	Alcohol use, unspecified with alcohol-induced mood disorder	
F10950	Alcohol use, unspecified with alcohol-induce psychotic disorder with delusions	
F10951	Alcohol use, unspecified with alcohol-induce psychotic disorder with hallucinations	
F10959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified	
F10980	Alcohol use, unspecified with alcohol-induced anxiety disorder	
F10981	Alcohol use, unspecified with alcohol-induced sexual dysfunction	
F10982	Alcohol use, unspecified with alcohol-induced sleep disorder	
F10988	Alcohol use, unspecified with other alcohol-induced disorder	
F1099	Alcohol use, unspecified with unspecified alcohol-induced disorder	
F1110	Opioid abuse, uncomplicated	
F1111	Opioid abuse, in remission	10/1/17
F11120	Opioid abuse with intoxication, uncomplicated	
F11121	Opioid abuse with intoxication delirium	
F11122	Opioid abuse with intoxication with perceptual disturbance	
F11129	Opioid abuse with intoxication, unspecified	
F1113	Opioid abuse with withdrawal	10/1/17
F1114	Opioid abuse with opioid-induced mood disorder	
F11150	Opioid abuse with opioid-induced psychotic disorder with delusions	
F11151	Opioid abuse with opioid-induced psychotic disorder with hallucinations	
F11159	Opioid abuse with opioid-induced psychotic disorder, unspecified	
F11181	Opioid abuse with opioid-induced sexual dysfunction	
F11182	Opioid abuse with opioid-induced sleep disorder	
F11188	Opioid abuse with other opioid-induced disorder	
F1119	Opioid abuse with unspecified opioid-induced disorder	

F1120	Opioid dependence, uncomplicated	
F1121	Opioid dependence, in remission	
F11220	Opioid dependence with intoxication, uncomplicated	
F11221	Opioid dependence with intoxication delirium	
F11222	Opioid dependence with intoxication with perceptual disturbance	
F11229	Opioid dependence with intoxication, unspecified	
F1123	Opioid dependence with withdrawal	
F1124	Opioid dependence with opioid-induced mood disorder	
F11250	Opioid dependence with opioid-induced psychotic disorder with delusions	
F11251	Opioid dependence with opioid-induced psychotic disorder with hallucinations	
F11259	Opioid dependence with opioid-induced psychotic disorder, unspecified	
F11281	Opioid dependence with opioid-induced sexual dysfunction	
F11282	Opioid dependence with opioid-induced sleep disorder	
F11288	Opioid dependence with other opioid-induced disorder	
F1129	Opioid dependence with unspecified opioid-induced disorder	
F1190	Opioid use, unspecified, uncomplicated	
F11920	Opioid use, unspecified with intoxication, uncomplicated	
F11921	Opioid use, unspecified with intoxication delirium	
F11922	Opioid use, unspecified with intoxication with perceptual disturbance	
F11929	Opioid use, unspecified with intoxication, unspecified	
F1193	Opioid use, unspecified with withdrawal	
F1194	Opioid use, unspecified with opioid-induced mood disorder	
F11950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions	
F11951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations	
F11959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified	
F11981	Opioid use, unspecified with opioid-induced sexual dysfunction	
F11982	Opioid use, unspecified with opioid-induced sleep disorder	
F11988	Opioid use, unspecified with other opioid-induced disorder	
F1199	Opioid use, unspecified with unspecified opioid-induced disorder	
F1210	Cannabis abuse, uncomplicated	
F1211	Cannabis abuse, in remission	10/1/17
F12120	Cannabis abuse with intoxication, uncomplicated	
F12121	Cannabis abuse with intoxication delirium	
F12122	Cannabis abuse with intoxication with perceptual disturbance	
F12129	Cannabis abuse with intoxication, unspecified	
F1213	Cannabis abuse with withdrawal	10/1/20
F12150	Cannabis abuse with psychotic disorder with delusions	

F12151	Cannabis abuse with psychotic disorder with hallucinations	
F12159	Cannabis abuse with psychotic disorder, unspecified	
F12180	Cannabis abuse with cannabis-induced anxiety disorder	
F12188	Cannabis abuse with other cannabis-induced disorder	
F1219	Cannabis abuse with unspecified cannabis-induced disorder	
F1220	Cannabis dependence, uncomplicated	
F1221	Cannabis dependence, in remission	
F12220	Cannabis dependence with intoxication, uncomplicated	
F12221	Cannabis dependence with intoxication delirium	
F12222	Cannabis dependence with intoxication with perceptual disturbance	
F12229	Cannabis dependence with intoxication, unspecified	
F12250	Cannabis dependence with psychotic disorder with delusions	
F12251	Cannabis dependence with psychotic disorder with hallucinations	
F12259	Cannabis dependence with psychotic disorder, unspecified	
F12280	Cannabis dependence with cannabis-induced anxiety disorder	
F12288	Cannabis dependence with other cannabis-induced disorder	
F1229	Cannabis dependence with unspecified cannabis-induced disorder	
F1290	Cannabis use, unspecified, uncomplicated	
F12920	Cannabis use, unspecified with intoxication, uncomplicated	
F12921	Cannabis use, unspecified with intoxication delirium	
F12922	Cannabis use, unspecified with intoxication with perceptual disturbance	
F12929	Cannabis use, unspecified with intoxication, unspecified	
F12950	Cannabis use, unspecified with psychotic disorder with delusions	
F12951	Cannabis use, unspecified with psychotic disorder with hallucinations	
F12959	Cannabis use, unspecified with psychotic disorder, unspecified	
F12980	Cannabis use, unspecified with anxiety disorder	
F12988	Cannabis use, unspecified with other cannabis-induced disorder	
F1299	Cannabis use, unspecified with unspecified cannabis-induced disorder	
F1310	Sedative, hypnotic or anxiolytic abuse, uncomplicated	
F1311	Sedative, Hypnotic or anxiolytic abuse in remission	10/1/17
F13120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated	
F13121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium	
F13129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified	
F13130	Sedative hypnotic or anxiolytic abuse with withdrawal, uncomplicated	10/1/20
F13131	Sedative hypnotic or anxiolytic abuse with withdrawal delirium	10/1/20
F13132	Sedative hypnotic or anxiolytic abuse with withdrawal with perceptual disturbance	10/1/20
F13139	Sedative hypnotic or anxiolytic abuse with withdrawal, unspecified	10/1/20
F1314	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder	

F13150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	
F13151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	
F13159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified	
F13180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder	
F13181	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction	
F13182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder	
F13188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder	
F1319	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder	
F1320	Sedative, hypnotic or anxiolytic dependence, uncomplicated	
F1321	Sedative, hypnotic or anxiolytic dependence, in remission	
F13220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated	
F13221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium	
F13229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified	
F13230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated	
F13231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium	
F13232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance	
F13239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified	
F1324	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder	
F13250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions	
F13251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations	
F13259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified	
F13280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder	
F13281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction	

F13282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder	
F13288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder	
F1329	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder	
F1390	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated	
F13920	Sedative, hypnotic, or anxiolytic use, unspecified with intoxication, uncomplicated	
F13921	Sedative, hypnotic, or anxiolytic use, unspecified with intoxication delirium	
F13929	Sedative, hypnotic, or anxiolytic use, unspecified with intoxication, unspecified	
F13930	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal, uncomplicated	
F13931	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal delirium	
F13932	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal with perceptual disturbances	
F13939	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal, unspecified	
F1394	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced mood disorder	
F13950	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced psychotic disorder with delusions	
F13951	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced psychotic disorder with hallucinations	
F13959	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced psychotic disorder with, unspecified	
F13980	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced anxiety disorder	
F13981	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced sexual dysfunction	
F13982	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced sleep disorder	
F13988	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic, or anxiolytic-induced disorder	
F1399	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic, or anxiolytic-induced disorder	
F1410	Cocaine abuse, uncomplicated	
F14120	Cocaine abuse with intoxication, uncomplicated	
F14121	Cocaine abuse with intoxication with delirium	
F14122	Cocaine abuse with intoxication with perceptual disturbance	

F14129	Cocaine abuse with intoxication, unspecified	
F1413	Cocaine abuse, unspecified with withdrawal	10/1/20
F1414	Cocaine abuse with cocaine-induced mood disorder	
F14150	Cocaine abuse with cocaine-induced psychotic disorder with delusions	
F14151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations	
F14159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified	
F14180	Cocaine abuse with cocaine-induced anxiety disorder	
F14181	Cocaine abuse with cocaine-induced sexual dysfunction	
F14182	Cocaine abuse with cocaine-induced sleep disorder	
F14188	Cocaine abuse with other cocaine-induced disorder	
F1419	Cocaine abuse with unspecified cocaine-induced disorder	
F1420	Cocaine dependence, uncomplicated	
F1421	Cocaine dependence, in remission	
F14220	Cocaine dependence with intoxication, uncomplicated	
F14221	Cocaine dependence with intoxication delirium	
F14222	Cocaine dependence with intoxication with perceptual disturbance	
F14229	Cocaine dependence with intoxication, unspecified	
F1423	Cocaine dependence with withdrawal	
F1424	Cocaine dependence with cocaine-induced mood disorder	
F14250	Cocaine dependence with cocaine-induced psychotic disorder with delusions	
F14251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations	
F14259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified	
F14280	Cocaine dependence with cocaine-induced anxiety disorder	
F14281	Cocaine dependence with cocaine-induced sexual dysfunction	
F14282	Cocaine dependence with cocaine-induced sleep disorder	
F14288	Cocaine dependence with other cocaine-induced disorder	
F1429	Cocaine dependence with unspecified cocaine-induced disorder	
F1490	Cocaine use, unspecified, uncomplicated	
F14920	Cocaine use, unspecified with intoxication, uncomplicated	
F14921	Cocaine use, unspecified with intoxication delirium	
F14922	Cocaine use, unspecified with intoxication with perceptual disturbance	
F14929	Cocaine use, unspecified with intoxication, unspecified	
F1493	Cocaine use, unspecified with Withdrawal	10/1/20
F1494	Cocaine use, unspecified with cocaine-induced mood disorder	
F14950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions	
F14951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations	

F14959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified	
F14980	Cocaine use, unspecified with cocaine-induced anxiety disorder	
F14981	Cocaine use, unspecified with cocaine-induced sexual dysfunction	
F14982	Cocaine use, unspecified with cocaine-induced sleep disorder	
F14988	Cocaine use, unspecified with other cocaine-induced disorder	
F1499	Cocaine use, unspecified with unspecified cocaine-induced disorder	
F1510	Other stimulant abuse, uncomplicated	
F15120	Other stimulant abuse with intoxication, uncomplicated	
F15121	Other stimulant abuse with intoxication delirium	
F15122	Other stimulant abuse with intoxication with perceptual disturbance	
F15129	Other stimulant abuse with intoxication, unspecified	
F1513	Other stimulant abuse with withdrawal	10/1/20
F1514	Other stimulant abuse with stimulant-induced mood disorder	
F15150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions	
F15151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations	
F15159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified	
F15180	Other stimulant abuse with stimulant-induced anxiety disorder	
F15181	Other stimulant abuse with stimulant-induced sexual dysfunction	
F15182	Other stimulant abuse with stimulant-induced sleep disorder	
F15188	Other stimulant abuse with other stimulant-induced disorder	
F1519	Other stimulant abuse with unspecified stimulant-induced disorder	
F1520	Other stimulant dependence, uncomplicated	
F1521	Other stimulant dependence, in remission	
F15220	Other stimulant dependence with intoxication, uncomplicated	
F15221	Other stimulant dependence with intoxication delirium	
F15222	Other stimulant dependence with intoxication with perceptual disturbance	
F15229	Other stimulant dependence with intoxication, unspecified	
F1523	Other stimulant dependence with withdrawal	
F1524	Other stimulant dependence with stimulant-induced mood disorder	
F15250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions	
F15251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations	
F15259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified	
F15280	Other stimulant dependence with stimulant-induced anxiety disorder	

F15281	Other stimulant dependence with stimulant-induced sexual dysfunction	
F15282	Other stimulant dependence with stimulant-induced sleep disorder	
F15288	Other stimulant dependence with other stimulant-induced disorder	
F1529	Other stimulant dependence with unspecified stimulant-induced disorder	
F1590	Other stimulant use, unspecified, uncomplicated	
F15920	Other stimulant use, unspecified with intoxication, uncomplicated	
F15921	Other stimulant use, unspecified with intoxication delirium	
F15922	Other stimulant use, unspecified with intoxication with perceptual disturbance	
F15929	Other stimulant use, unspecified with intoxication, unspecified	
F1593	Other stimulant use, unspecified with withdrawal	
F1594	Other stimulant use, unspecified with stimulant-induced mood disorder	
F15950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions	
F15951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations	
F15959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified	
F15980	Other stimulant use, unspecified with stimulant-induced anxiety disorder	
F15981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction	
F15982	Other stimulant use, unspecified with stimulant-induced sleep disorder	
F15988	Other stimulant use, unspecified with other stimulant-induced disorder	
F1599	Other stimulant use, unspecified with unspecified stimulant-induced disorder	
F1610	Hallucinogen abuse, uncomplicated	
F16120	Hallucinogen abuse with intoxication, uncomplicated	
F16121	Hallucinogen abuse with intoxication with delirium	
F16122	Hallucinogen abuse with intoxication with perceptual disturbance	
F16129	Hallucinogen abuse with intoxication, unspecified	
F1614	Hallucinogen abuse with hallucinogen-induced mood disorder	
F16150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions	
F16151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations	
F16159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified	
F16180	Hallucinogen abuse with hallucinogen-induced anxiety disorder	
F16183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)	
F16188	Hallucinogen abuse with other hallucinogen-induced disorder	
F1619	Hallucinogen abuse with unspecified hallucinogen-induced disorder	

F1620	Hallucinogen dependence, uncomplicated	
F1621	Hallucinogen dependence, in remission	
F16220	Hallucinogen dependence with intoxication, uncomplicated	
F16221	Hallucinogen dependence with intoxication with delirium	
F16229	Hallucinogen dependence with intoxication, unspecified	
F1624	Hallucinogen dependence with hallucinogen-induced mood disorder	
F16250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions	
F16251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations	
F16259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified	
F16280	Hallucinogen dependence with hallucinogen-induced anxiety disorder	
F16283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)	
F16288	Hallucinogen dependence with other hallucinogen-induced disorder	
F1629	Hallucinogen dependence with unspecified hallucinogen-induced disorder	
F1690	Hallucinogen use, unspecified, uncomplicated	
F16920	Hallucinogen use, unspecified with intoxication, uncomplicated	
F16921	Hallucinogen use, unspecified with intoxication with delirium	
F16929	Hallucinogen use, unspecified with intoxication, unspecified	
F1694	Hallucinogen use, unspecified with hallucinogen-induced mood disorder	
F16950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions	
F16951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations	
F16959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified	
F16980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder	
F16983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)	
F16988	Hallucinogen use, unspecified with other hallucinogen-induced disorder	
F1699	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder	
F17200	Nicotine dependence, unspecified, uncomplicated	
F17201	Nicotine dependence, unspecified, in remission	
F17203	Nicotine dependence unspecified, with withdrawal	
F17208	Nicotine dependence, unspecified, with other nicotine-induced disorders	
F17209	Nicotine dependence, unspecified, with unspecified nicotine-induced disorders	
F17210	Nicotine dependence, cigarettes, uncomplicated	

F17211	Nicotine dependence, cigarettes, in remission	
F17213	Nicotine dependence, cigarettes, with withdrawal	
F17218	Nicotine dependence, cigarettes, with other nicotine-induced disorders	
F17219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders	
F17220	Nicotine dependence, chewing tobacco, uncomplicated	
F17221	Nicotine dependence, chewing tobacco, in remission	
F17223	Nicotine dependence, chewing tobacco, with withdrawal	
F17228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders	
F17229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders	
F17290	Nicotine dependence, other tobacco product, uncomplicated	
F17291	Nicotine dependence, other tobacco product, in remission	
F17293	Nicotine dependence, other tobacco product, with withdrawal	
F17298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders	
F17299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders	
F1810	Inhalant abuse, uncomplicated	
F18120	Inhalant abuse with intoxication, uncomplicated	
F18121	Inhalant abuse with intoxication delirium	
F18129	Inhalant abuse with intoxication, unspecified	
F1814	Inhalant abuse with inhalant-induced mood disorder	
F18150	Inhalant abuse with inhalant-induced psychotic disorder with delusions	
F18151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations	
F18159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified	
F1817	Inhalant abuse with inhalant-induced dementia	
F18180	Inhalant abuse with inhalant-induced anxiety disorder	
F18188	Inhalant abuse with other inhalant-induced disorder	
F1819	Inhalant abuse with unspecified inhalant-induced disorder	
F1820	Inhalant dependence, uncomplicated	
F1821	Inhalant dependence, in remission	
F18220	Inhalant dependence with intoxication, uncomplicated	
F18221	Inhalant dependence with intoxication delirium	
F18229	Inhalant dependence with intoxication, unspecified	
F1824	Inhalant dependence with inhalant-induced mood disorder	
F18250	Inhalant dependence with inhalant-induced psychotic disorder with delusions	

F18251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations	
F18259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified	
F1827	Inhalant dependence with inhalant-induced dementia	
F18280	Inhalant dependence with inhalant-induced anxiety disorder	
F18288	Inhalant dependence with other inhalant-induced disorder	
F1829	Inhalant dependence with unspecified inhalant-induced disorder	
F1890	Inhalant use, unspecified, uncomplicated	
F18920	Inhalant use, unspecified with intoxication, uncomplicated	
F18921	Inhalant use, unspecified with intoxication with delirium	
F18929	Inhalant use, unspecified with intoxication, unspecified	
F1894	Inhalant use, unspecified with inhalant-induced mood disorder	
F18950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions	
F18951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations	
F18959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified	
F18980	Inhalant use, unspecified with inhalant-induced anxiety disorder	
F18988	Inhalant use, unspecified with other inhalant-induced disorder	
F1899	Inhalant use, unspecified with unspecified inhalant-induced disorder	
F1910	Other psychoactive substance abuse, uncomplicated	
F19120	Other psychoactive substance abuse with intoxication, uncomplicated	
F19121	Other psychoactive substance abuse with intoxication delirium	
F19122	Other psychoactive substance abuse with intoxication with perceptual disturbances	
F19129	Other psychoactive substance abuse with intoxication, unspecified	
F19130	Other psychoactive substance abuse with withdrawal uncomplicated	10/1/20
F19131	Other psychoactive substance abuse with withdrawal delirium	10/1/20
F19132	Other psychoactive substance abuse with withdrawal with perceptional disturbance	10/1/20
F19139	Other psychoactive substance abuse with withdrawal, unspecified	10/1/20
F1914	Other psychoactive substance abuse with psychoactive substance-induced mood disorder	
F19150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions	
F19151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations	
F19159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified	

F19180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder	
F19181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction	
F19182	Other psychoactive substance abuse with psychoactive substance-induced sleep disorder	
F19188	Other psychoactive substance abuse with other psychoactive substance-induced disorder	
F1919	Other psychoactive substance abuse with unspecified substance-induced disorder	
F1920	Other psychoactive substance dependence, uncomplicated	
F1921	Other psychoactive substance dependence, in remission	
F19220	Other psychoactive substance dependence with intoxication, uncomplicated	
F19221	Other psychoactive substance dependence with intoxication delirium	
F19222	Other psychoactive substance dependence with intoxication with perceptual disturbance	
F19229	Other psychoactive substance dependence with intoxication, unspecified	
F19230	Other psychoactive substance dependence with withdrawal, uncomplicated	
F19231	Other psychoactive substance dependence with withdrawal delirium	
F19232	Other psychoactive substance dependence with withdrawal with perceptual disturbance	
F19239	Other psychoactive substance dependence with withdrawal, unspecified	
F1924	Other psychoactive substance dependence with psychoactive substance-induced mood disorder	
F19250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions	
F19251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations	
F19259	Other psychoactive substance dependence with substance-induced psychotic disorder, unspecified	
F19280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder	
F19281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction	
F19282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder	
F19288	Other psychoactive substance dependence with other psychoactive substance-induced disorder	

F1929	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder	
F1990	Other psychoactive substance use, unspecified, uncomplicated	
F19920	Other psychoactive substance use, unspecified with intoxication, uncomplicated	
F19921	Other psychoactive substance use, unspecified with intoxication with delirium	
F19922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance	
F19929	Other psychoactive substance use, unspecified with intoxication, unspecified	
F19930	Other psychoactive substance use, unspecified with withdrawal, uncomplicated	
F19931	Other psychoactive substance use, unspecified with withdrawal delirium	
F19932	Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance	
F19939	Other psychoactive substance use, unspecified with withdrawal, unspecified	
F1994	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder	
F19950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions	
F19951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations	
F19959	Other psychoactive substance use, unspecified with psychoactive disorder, unspecified	
F19980	Other psychoactive substance use, unspecified with anxiety disorder	
F19981	Other psychoactive substance use, unspecified with sexual dysfunction	
F19982	Other psychoactive substance use, unspecified with sleep disorder	
F19988	Other psychoactive substance use, unspecified with other disorder	
F1999	Other psychoactive substance use, unspecified with unspecified disorder	
O99310	Alcohol use complicating pregnancy, unspecified trimester	
O99311	Alcohol use complicating pregnancy, first trimester	
O99312	Alcohol use complicating pregnancy, second trimester	
O99313	Alcohol use complicating pregnancy, third trimester	
O99314	Alcohol use complicating childbirth	
O99315	Alcohol use complicating the puerperium	
O99320	Drug use complicating pregnancy, unspecified trimester	
O99321	Drug use complicating pregnancy, first trimester	
O99322	Drug use complicating pregnancy, second trimester	
O99323	Drug use complicating pregnancy, third trimester	

O99324	Drug use complicating childbirth	
O99325	Drug use complicating the puerperium	
R780	Finding of alcohol in blood	
R781	Finding of opiate drug in blood	
R782	Finding of cocaine in blood	
R783	Finding of hallucinogen in blood	
R784	Finding of other drugs of addictive potential in blood	
R785	Finding of other psychotropic drug in blood	

Mental Health ICD-10 Codes
Maryland Department of Health

For dates of service on or after October 1, 2015:

Code	Diagnosis Description	Revision Date
F200	Paranoid schizophrenia	
F201	Disorganized schizophrenia	
F202	Catatonic schizophrenia	
F203	Undifferentiated schizophrenia	
F205	Residual schizophrenia	
F2081	Schizophreniform disorder	
F2089	Other schizophrenia	
F209	Schizophrenia, unspecified	
F21	Schizotypal disorder	
F22	Delusional disorders	
F23	Brief psychotic disorder	
F24	Shared psychotic disorder	
F250	Schizoaffective disorder, bipolar type	
F251	Schizoaffective disorder, depressive type	
F258	Other schizoaffective disorders	
F259	Schizoaffective disorder, unspecified	
F28	Other psychotic disorder not due to a substance or known physiological condition	
F29	Unspecified psychosis not due to a substance or known physiological condition	
F3010	Manic episode without psychotic symptoms, unspecified	
F3011	Manic episode without psychotic symptoms, mild	
F3012	Manic episode without psychotic symptoms, moderate	
F3013	Manic episode, severe, without psychotic symptoms	
F302	Manic episode, severe with psychotic symptoms	
F303	Manic episode in partial remission	
F304	Manic episode in full remission	
F308	Other manic episodes	
F309	Manic episode, unspecified	
F310	Bipolar disorder, current episode hypomanic	
F3110	Bipolar disorder, current episode manic without psychotic features, unspecified	
F3111	Bipolar disorder, current episode manic without psychotic features, mild	

F3112	Bipolar disorder, current episode manic without psychotic features, mod	
F3113	Bipolar disorder, current episode manic without psychotic features, severe	
F312	Bipolar disorder, current episode manic severe with psychotic features	
F3130	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified	
F3131	Bipolar disorder, current episode depressed, mild	
F3132	Bipolar disorder, current episode depressed, moderate	
F314	Bipolar disorder, current episode depressed, severe, without psychotic features	
F315	Bipolar disorder, current episode depressed, severe, with psychotic features	
F3160	Bipolar disorder, current episode mixed, unspecified	
F3161	Bipolar disorder, current episode mixed, mild	
F3162	Bipolar disorder, current episode mixed, moderate	
F3163	Bipolar disorder, current episode mixed, severe, without psychotic features	
F3164	Bipolar disorder, current episode mixed, severe, with psychotic features	
F3170	Bipolar disorder, currently in remission, most recent episode unspecified	
F3171	Bipolar disorder, in partial remission, most recent episode hypomanic	
F3172	Bipolar disorder, in full remission, most recent episode hypomanic	
F3173	Bipolar disorder, in partial remission, most recent episode manic	
F3174	Bipolar disorder, in full remission, most recent episode manic	
F3175	Bipolar disorder, in partial remission, most recent episode depressed	
F3176	Bipolar disorder, in full remission, most recent episode depressed	
F3177	Bipolar disorder, in partial remission, most recent episode mixed	
F3178	Bipolar disorder, in full remission, most recent episode mixed	
F3181	Bipolar II disorder	
F3189	Other bipolar disorder	
F319	Bipolar disorder, unspecified	
F320	Major depressive disorder, single episode, mild	
F32A	Depression, unspecified	10/1/21

F321	Major depressive disorder, single episode, moderate	
F322	Major depressive disorder, single episode, severe without psychotic features	
F323	Major depressive disorder, single episode, severe with psychotic features	
F324	Major depressive disorder, single episode, in partial remission	
F325	Major depressive disorder, single episode, in full remission	
F328	Other depressive episodes	Termed 9-30-16
F3281	Premenstrual dysphoric disorder	Effective 10/1/2016
F3289	Other specified depressive episodes	Effective 10/1/2016
F329	Major depressive disorder, single episode, unspecified	
F330	Major depressive disorder, recurrent, mild	
F331	Major depressive disorder, recurrent, moderate	
F332	Major depressive disorder, recurrent severe without psychotic features	
F333	Major depressive disorder, recurrent, severe with psychotic symptoms	
F3340	Major depressive disorder, recurrent, in remission, unspecified	
F3341	Major depressive disorder, recurrent, in partial remission	
F3342	Major depressive disorder, recurrent, in full remission	
F338	Other recurrent depressive disorders	
F339	Major depressive disorder, recurrent, unspecified	
F340	Cyclothymic disorder	
F341	Dysthymic disorder	
F348	Other persistent mood [affective] disorders	Termed 9-30-16
F3481	Disruptive mood dysregulation disorder	Effective 10/1/2016
F3489	Other specified persistent mood disorders	
F349	Persistent mood (affective) disorder, unspecified	
F39	Unspecified mood (affective) disorder	
F4000	Agoraphobia, unspecified	
F4001	Agoraphobia with panic disorder	
F4002	Agoraphobia without panic disorder	
F4010	Social phobia, unspecified	
F4011	Social phobia, generalized	
F40210	Arachnophobia	
F40218	Other animal type phobia	
F40220	Fear of thunderstorms	

F40228	Other natural environment type phobia	
F40230	Fear of blood	
F40231	Fear of injections and transfusions	
F40232	Fear of other medical care	
F40233	Fear of injury	
F40240	Claustrophobia	
F40241	Acrophobia	
F40242	Fear of bridges	
F40243	Fear of flying	
F40248	Other situational type phobia	
F40290	Androphobia	
F40291	Gynephobia	
F40298	Other specified phobia	
F408	Other phobic anxiety disorders	
F409	Phobic anxiety disorder, unspecified	
F410	Panic disorder without agoraphobia	
F411	Generalized anxiety disorder	
F413	Other mixed anxiety disorders	
F418	Other specified anxiety disorders	
F419	Anxiety disorder, unspecified	
F42	Obsessive-compulsive disorder	Terminated 9-30-16
F422	Mixed obsessional thoughts and acts	Effective 10/1/2016
F423	Hoarding disorder	Effective 10/1/2016
F424	Excoriation (skin-picking) disorder	Effective 10/1/2016
F428	Other obsessive compulsive disorder	Effective 10/1/2016
F429	Obsessive-compulsive disorder, unspecified	Effective 10/1/2016
F430	Acute stress reaction	
F4310	Post-traumatic stress disorder, unspecified	
F4311	Post-traumatic stress disorder, acute	
F4312	Post-traumatic stress disorder, chronic	
F4320	Adjustment disorder, unspecified	
F4321	Adjustment disorder with depressed mood	
F4322	Adjustment disorder with anxiety	
F4323	Adjustment disorder with mixed anxiety and depressed mood	
F4324	Adjustment disorder with disturbance of conduct	

F4325	Adjustment disorder with mixed disturbance of emotions and conduct	
F4329	Adjustment disorder with other symptoms	
F438	Other reactions to severe stress	
F439	Reaction to severe stress, unspecified	
F440	Dissociative amnesia	
F441	Dissociative fugue	
F442	Dissociative stupor	
F444	Conversion disorder with motor symptom or deficit	
F446	Conversion disorder with sensory symptom or deficit	
F4481	Dissociative identity disorder	
F4489	Other dissociative and conversion disorders	
F449	Dissociative and conversion disorder, unspecified	
F450	Somatization disorder	
F451	Undifferentiated somatoform disorder	
F4520	Hypochondriacal disorder, unspecified	
F4521	Hypochondriasis	
F4522	Body dysmorphic disorder	
F4529	Other hypochondriacal disorders	
F4541	Pain disorder exclusively related to psychological factors	
F458	Other somatoform disorders	
F459	Somatoform disorder, unspecified	
F481	Depersonalization-derealization syndrome	
F488	Other specified nonpsychotic mental disorders	
F489	Nonpsychotic mental disorder, unspecified	
F5000	Anorexia nervosa, unspecified	
F5001	Anorexia nervosa, restricting type	
F5002	Anorexia nervosa, binge eating/purging type	
F502	Bulimia nervosa	
F508	Other eating disorders	Terminated 9/30/18
F5081	Binge eating disorder	Effective 10/1/2016
F5082	Avoidant/restrictive food intake disorder	
F5089	Other specified eating disorder	Effective 10/1/2016
F509	Eating disorder, unspecified	
F53	Puerperal psychosis	
F530	Postpartum depression	Effective 10/1/18
F531	Puerperal psychosis	Effective 10/1/18

F54	Psychological and behavioral factors associated with disorders or diseases classified elsewhere	
F600	Paranoid personality disorder	
F601	Schizoid personality disorder	
F603	Borderline personality disorder	
F604	Histrionic personality disorder	
F605	Obsessive-compulsive personality disorder	
F606	Avoidant personality disorder	
F607	Dependent personality disorder	
F6081	Narcissistic personality disorder	
F6089	Other specific personality disorders	
F609	Personality disorder, unspecified	
F630	Pathological gambling	
F631	Pyromania	
F632	Kleptomania	
F633	Trichotillomania	
F6381	Intermittent explosive disorder	
F6389	Other impulse disorders	
F639	Impulse disorder, unspecified	
F640	Transsexualism	Effective 10/1/2016
F641	Gender identity disorder in adolescence and adulthood	
F642	Gender identity disorder of childhood	
F648	Other gender identity disorders	
F649	Gender identity disorder, unspecified	
F650	Fetishism	
F651	Transvestic fetishism	
F652	Exhibitionism	
F653	Voyeurism	
F654	Pedophilia	
F6550	Sadomasochism, unspecified	
F6551	Sexual masochism	
F6552	Sexual sadism	
F6581	Frotteurism	
F6589	Other paraphilias	
F659	Paraphilia, unspecified	
F66	Other sexual disorders	
F6811	Factitious disorder with predominantly psychological signs and symptoms	
F6813	Factitious disorder with combined psychological and physical signs and symptoms	

F688	Other specified disorders of adult personality and behavior	
F69	Unspecified disorder of adult personality and behavior	
F843	Other childhood disintegrative disorder	
F900	Attention-deficit hyperactivity disorder, predominantly inattentive type	
F901	Attention-deficit hyperactivity disorder, predominantly hyperactive type	
F902	Attention-deficit hyperactivity disorder, combined type	
F908	Attention-deficit hyperactivity disorder, other type	
F909	Attention-deficit hyperactivity disorder, unspecified type	
F910	Conduct disorder confined to family context	
F911	Conduct disorder, childhood-onset type	
F912	Conduct disorder, adolescent-onset type	
F913	Oppositional defiant disorder	
F918	Other conduct disorders	
F919	Conduct disorder, unspecified	
F930	Separation anxiety disorder of childhood	
F938	Other childhood emotional disorders	
F939	Childhood emotional disorder, unspecified	
F940	Selective mutism	
F941	Reactive attachment disorder of childhood	
F942	Disinhibited attachment disorder of childhood	
F948	Other childhood disorders of social functioning	
F949	Childhood disorder of social functioning, unspecified	
F980	Enuresis not due to a substance or known physiological condition	
F981	Encopresis not due to a substance or known physiological condition	
F984	Stereotyped movement disorders	
F988	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence	
F989	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence	
F99	Mental disorder, not otherwise specified	
G2111	Neuroleptic induced parkinsonism	
G2402	Drug induced acute dystonia	
G2589	Other specified extrapyramidal and movement disorders	
G259	Extrapyramidal and movement disorder, unspecified	
R457	State of emotional shock and stress, unspecified	
R45850	Homicidal ideations	
R45851	Suicidal ideations	

O99340	Other mental disorders complicating pregnancy, unspecified trimester	
O99341	Other mental disorders complicating pregnancy, first trimester	
O99342	Other mental disorders complicating pregnancy, second trimester	
O99343	Other mental disorders complicating pregnancy, third trimester	
O99344	Other mental disorders complicating childbirth	
O99345	Other mental disorders complicating the puerperium	
Z046	Encounter for general psychiatric examination requested by the authority	

An MCO is not responsible for services billed by a psychiatrist when the claim includes one of the following primary diagnoses:

G24.4	Orofacial dyskinesia
G25.1	Drug-induced tremor
G21.0	Neuroleptic malignant syndrome

Attachment J:
Provider Grievance /
Appeal Form

JAI MEDICAL SYSTEMS

301 INTERNATIONAL CIRCLE • HUNT VALLEY, MARYLAND 21030
1-888-JAI-1999 • TELEPHONE 410 - 433 - 2200 • FAX 410 - 433 - 4615

PROVIDER GRIEVANCE FORM

Date: _____

Name: _____

Organization: _____ Provider: _____

Address: _____

_____

Phone Number: _____

Detailed Explanation of Issue: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Reason(s) for filing Grievance: _____
_____
_____
_____
_____
_____
_____

Note: *You will receive written acknowledgement of your grievance within the next 3 business days. If you have any questions, please contact the Provider Relations Department at 410-433-2200 or 1-888-JAI-1999. We apologize for any inconvenience and look forward to working with you to address your concerns. Thank you!*

JAI MEDICAL SYSTEMS

301 INTERNATIONAL CIRCLE • HUNT VALLEY, MARYLAND 21030
1-888-JAI-1999 • TELEPHONE 410 - 433 - 2200 • FAX 410 - 433 - 4615

PROVIDER APPEAL FORM

Date: _____

Name: _____

Organization: _____ Provider: _____

Address: _____

_____

Phone Number: _____

Detailed Explanation of Issue: _____

Reason(s) for filing Appeal: _____

Note: *You will receive written acknowledgement of your grievance within the next 3 business days. If you have any questions, please contact the Provider Relations Department at 410-433-2200 or 1-888-JAI-1999. We apologize for any inconvenience and look forward to working with you to address your concerns. Thank you!*

Attachment K:
Request for Fair Hearing Form

REQUEST FOR A FAIR HEARING

Name: _____

Address: _____

_____

Phone #: _____

Medical Assistance Number (Found on Your Red & White Card**):** _____

I disagree with Jai Medical Systems decision because: _____

_____

_____

_____

_____

_____

_____

_____

Please schedule my fair hearing within 20 days of the date you receive this request.

Thank you,

_____
Signature

Send the completed form to:

Jai Medical Systems Managed Care Organization, Inc.
Attn: Customer Service Director
301 International Circle
Hunt Valley, Maryland 21030

If you need help filling out this form, please call Jai Medical Systems Customer Service Department at 1-888-JAI-1999 or 1-888-524-1999.

Attachment L:
Provider Appeal and
Grievance Rights

JAI MEDICAL SYSTEMS

301 INTERNATIONAL CIRCLE • HUNT VALLEY, MARYLAND 21030
1-888-JAI-1999 • TELEPHONE 410 - 433 - 2200 • FAX 410 - 433 - 4615

Provider Appeal and Grievance Rights

What is an appeal?	An appeal is a review by the MCO or the Maryland Department of Health when you are dissatisfied with a decision that impacts your practice or patients.
Why would I appeal?	Examples of reasons to file an appeal include: • Jai Medical Systems does not resolve a grievance or appeal to your satisfaction. • Jai Medical Systems limits, reduces, suspends, or terminates a contractual agreement. • Jai Medical Systems denies all or part of payment for a service you've rendered. • Jai Medical Systems provides the results from a quality or profession review with which you disagree. • Jai Medical Systems fails to provide services in a timely manner, as defined by the Maryland Department of Health.
What is a grievance?	A grievance is when you express dissatisfaction with the MCO or another provider.
Why would I file a grievance?	You may file a grievance anytime you are dissatisfied with the services provided by Jai Medical Systems.

Filing an Appeal

How do I appeal to Jai Medical Systems	You, or your authorized representative, may appeal Jai Medical Systems' decision within 185 days from the date of the denial notice. Please complete and return the attached appeal form, along with any supporting documentation, to: Jai Medical Systems Managed Care Organization Provider Relations Department 301 International Circle Hunt Valley, MD 21030 Jai Medical Systems will send you a notice to confirm receipt of the appeal. If you would like assistance from the Maryland Department of Health with appealing to Jai Medical Systems, call the HealthChoice Provider Relations Department at 410-767-5503.

How long will Jai Medical Systems take to resolve my appeal?	Appeal decision timeframes vary, depending on urgency, but Jai Medical Systems will aim to make a determination within 30 days of the receipt of your appeal. Jai Medical Systems may require more time to gather additional information to resolve the appeal. If the Jai Medical Systems requires more time, Jai Medical Systems will send you a written notice. Jai Medical Systems Provider Relations Department is available at 1-888-JAI-1999 for questions or concerns.

Filing a Grievance

How do I file a grievance?	You can file a grievance with Jai Medical Systems or the Maryland Department of Health. To file a grievance with Jai Medical Systems, please complete and return the attached grievance form to: Jai Medical Systems Managed Care Organization Provider Relations Department 301 International Circle Hunt Valley, MD 21030 Jai Medical Systems will confirm the receipt of the grievance, in writing, and send you a notice when it is resolved. Jai Medical Systems Provider Relations Department is available at 1-888-JAI-1999 for questions or concerns. To file a grievance with the Maryland Department of Health, call the HealthChoice Provider Relations Department at 410-767-5503.
When can I file a grievance?	You may file a grievance at any time.
How long does it take to resolve a grievance?	For administrative grievances, you will receive a resolution no later than 30 days from the date of filing your grievance. For medical grievances, you will receive a resolution within 24 hours if it is an emergency and within 5 days if it is not an emergency. Jai Medical Systems may require more time to gather additional information to resolve the grievance. If the Jai Medical Systems requires more time, Jai Medical Systems will send you a written notice.

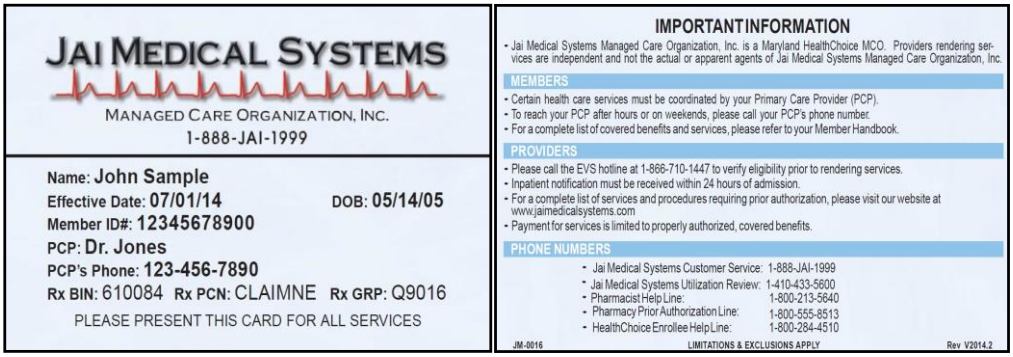
Attachment M:
Provider Quick Reference Guide

JAI MEDICAL SYSTEMS

Provider Quick Reference Guide

Thank you for being a participating provider with Jai Medical Systems Managed Care Organization. We have developed this quick reference guide to assist our providers. For the most up-to-date information about Jai Medical Systems, please visit our website at www.jaimedicalsystems.com. Our website provides detailed information regarding our Clinical Guidelines, Utilization Management Program, Formulary, Quality Assurance Program, Disease Management Programs, Member Rights and Responsibilities, Prior Authorization Requirements, and Online Provider Directory.

Member Identification Card



Eligibility Verification

Please call the Maryland Department of Health (MDH) Eligibility Verification System (EVS) at 1-866-710-1447, on the date of service to verify member eligibility. You may also verify eligibility online using the MDH's EVS system at https://encrypt.emdhealthchoice.org/emedicaid/.

If you have any specific questions about a member's eligibility after using EVS, please call the Jai Medical Systems Customer Service Department at 1-888-JAI-1999.

Important Phone & Fax Numbers

For general information regarding Jai Medical Systems and for Customer Service support, please contact us at 1-888-JAI-1999**.** By calling this number, you may reach our Provider Relations Department, Case Management Department, as well as receive information regarding Claims and Appeals.

Important Phone Numbers

Jai Medical Systems	1-888-JAI-1999
Eligibility Verification System	1-866-710-1447
Pharmacist Help Line	1-800-213-5640
Pharmacy Prior Authorization	1-800-555-8513
Behavioral Health (Optum)	1-800-888-1965
DentaQuest	1-855-398-8414
Maryland Healthy Smiles (Scion)	1-855-934-9812
Superior Vision	1-800-879-6901

Important Fax Numbers

Provider Relations	410-433-4615 or 410-403-1816
Customer Service	410-856-1075
Utilization/Case Management	410-433-8500
Authorizations/Referrals Fax Line	1-866-381-7200

ACCREDITED NCQA HEALTH PLAN EXCELLENT

Referrals

Primary Care Provider (PCP) Responsibilities
Each member's PCP is responsible for issuing referrals for care beyond the scope of the PCP's practice. Please use either the Jai Medical Systems Referral Form or the Maryland Uniform Consultation Referral Form. Please complete the form legibly. To request Jai Medical Systems referral forms, please contact our Provider Relations Department.

Please fax all completed referral forms to 1-866-381-7200. Please only refer members in-network to participating providers listed in the Jai Medical Systems Provider Directory, which is available online.

If you are having difficulty locating a particular provider, please contact our Provider Relations Department for assistance.

Specialist Responsibilities

Please send reports to the PCP on clinical findings and follow-up with the PCP on the referral results and future needs of the member.

When submitting claims, please attach the referral to your claim. If the claim is submitted electronically, please fax the referral to 1-866-381-7200 prior to submitting the claim.

Pre-Certification & Prior Authorization

Please visit our website, www.jaimedicalsystems.com, for a comprehensive list of services that require pre-certification and/or prior authorization.

For questions regarding prior authorization of a service and/or procedure, please contact the Utilization Management Department at 410-433-5600.

Claims & Appeals

Electronic Claims: To submit electronic claims, please register at www.claimsnet.com/jai.

Paper Claims: Please mail paper claims to 301 International Circle, Hunt Valley, MD 21030, Attn: Claims Department. Please attach a copy of the authorization or referral form to each claim, if applicable.

For information regarding paper and electronic claims submissions, as well as the claims appellate process, please visit our website at www.jaimedicalsystems.com.

Pharmacy

Please prescribe covered medications listed on the Jai Medical Systems Formulary, unless medically necessary circumstances dictate non-formulary prescriptions. Our formulary can be found online at www.jaimedicalsystems.com, or through Formulary Navigator.

Formulary medications marked with a "PA" require a prior authorization. Please refer to the Formulary for instructions on how to submit a prior authorization request for these medications. If you have questions about our pharmacy benefits, please contact ProCare Rx at 1-800-213-5640.

Radiology

Jai Medical Systems is contracted with RadNet for radiology services. RadNet's organizations include Advanced Radiology, American Radiology, Maryland Imaging Network and Community Radiology. Please visit our website at www.jaimedicalsystems.com, for a complete listing of RadNet locations.

Laboratory

Jai Medical Systems is contracted with LabCorp for all laboratory services. Please ensure that our members receive laboratory services from LabCorp. LabCorp maintains drawing stations throughout Maryland and provider drop boxes are available from LabCorp, upon request. If you have any questions, please feel free to contact LabCorp at 1-800-859-0391.

Participating Hospitals

Calvert Memorial Hospital
Carroll Hospital Center
Chester River Hospital Center
Doctor's Community Hospital
Dorchester General Hospital
Franklin Square Hospital
Good Samaritan Hospital
Greater Baltimore Medical Center
Harbor Hospital Center
Howard County General Hospital
Johns Hopkins Bayview Medical Center
Johns Hopkins Hospital
Levindale Hebrew Geriatric Center and Hospital
McCready Memorial Hospital
Memorial Hospital at Easton
Mercy Medical Center
Mt. Washington Pediatric Hospital
Northwest Hospital Center
Sinai Hospital of Baltimore
UM Baltimore Washington Medical Center
UM Charles Regional Medical Center
UM St. Joseph Medical Center
UMMC Midtown Campus
Union Memorial Hospital
University of Maryland Medical Center
University of Maryland Rehabilitation & Orthopedic Institute

Attachment N:
Member Rights and Responsibilities

Member Rights and Responsibilities

As a HealthChoice member, you have the right to:

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

As a HealthChoice member, you have the responsibility to:

- Inform your provider and MCO if you have any other health insurance coverage.
- Treat HealthChoice staff, MCO staff, and health care providers and staff, with respect and dignity.
- Be on time for appointments and notify providers as soon as possible if you need to cancel an appointment.
- Show your membership card when you check in for every appointment. Never allow anyone else to use your Medicaid or MCO card. Report lost or stolen member ID cards to the MCO.
- Call your MCO if you have a problem or a complaint.

- Work with your Primary Care Provider (PCP) to create and follow a plan of care that you and your PCP agree on.
- Ask questions about your care and let your provider know if there is something you do not understand.
- To understand your health problems and to work with your provider to create mutually agreed upon treatment goals that you will follow.
- Update the State if there has been a change in your status.
- Provide the MCO and their providers with accurate health information in order to provide proper care.
- Use the emergency department for emergencies only.
- Tell your PCP as soon as possible after you receive emergency care.
- Inform your caregivers about any changes to your Advance Directives.

Attachment O:
HIPAA and Member Privacy Rights

JAI MEDICAL SYSTEMS
301 INTERNATIONAL CIRCLE • HUNT VALLEY, MARYLAND 21030 • TELEPHONE 410.433.2200
FAX 410.433.4615 • TOLL FREE 1.888.JAI.1999

Notice of Privacy Practices

This notice describes how medical information about you is protected, may be used and disclosed, and how you can get access to this information. Please review it carefully.

Safeguarding Your Protected Health Information

Jai Medical Systems Managed Care Organization, Inc. (Jai Medical Systems) is committed to protecting your health information. In order to help coordinate or to pay for your health care, Jai Medical Systems will ask for certain health information. This information will be put into your health information record. Your health information may contain your symptoms, examination and test results, diagnoses, and treatment. Your health information may be used for a variety of purposes and is regulated by law. Jai Medical Systems protects your PHI in several ways, such as restricting physical and electronic access, by requiring appropriate member authorization for release of information as required by law, and by requiring all employees to sign confidentiality agreements. Jai Medical Systems is required to maintain the privacy of your oral, written, and electronic health information, to give you this Notice of our legal duties and privacy practices with respect to your health information, and to follow the privacy practices described in this Notice. However, Jai Medical Systems reserves the right to change our privacy practices and the terms of this Notice at any time and to make the new provisions effective for all health information we have about you and any information we receive in the future. You may request a copy of the current Notice from Jai Medical Systems at any time. This Notice can be found in your Member Handbook and is mailed to all members once a year. The current Notice is also posted on our website, and we will mail a copy to you upon request.

How Jai Medical Systems May Use and Disclose Your Protected Health Information

Jai Medical Systems employees will only use your health information to do their jobs. For uses and disclosure beyond what Jai Medical Systems normally does (as described in this Notice), Jai Medical Systems must have your written authorization unless the law permits or requires otherwise. Many uses of psychotherapy notes, certain uses and disclosures of your health information for marketing purposes, and any sale of your health information require your authorization. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization. (You also cannot revoke an authorization that was obtained as a condition of obtaining insurance coverage and other law provides Jai Medical Systems with the right to contest a claim under the policy or the policy itself.) The following are some examples of our possible uses and disclosures of your health information:

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations:**
  - **For Treatment:** Jai Medical Systems may use or share your health information for the provision, coordination, or management of health care. For example, Jai Medical Systems' employees may need to review your treatment plan with your health care provider for coordination of care.
  - **To Obtain Payment:** Jai Medical Systems may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate with our services. For example, your health care provider may send claims for payment of medical services provided to you, or Jai Medical Systems may need to use or share your health information to determine if your treatment is medically necessary, appropriate, or otherwise covered.

- **For Health Care Operations:** Jai Medical Systems may use and share your health information for health care operations, including to evaluate the quality of services provided, to provide case management and care coordination, to engage in underwriting and enrollment activities, and/or as requested by State or Federal auditors. Jai Medical Systems will not use or share any genetic information about you for underwriting purposes, including determinations of eligibility.

- **CRISP**: Jai Medical Systems has chosen to participate in the Chesapeake Regional Information System for Our Patients (CRISP), a statewide internet-based health information exchange approved but not operated by a State of Maryland agency. As permitted by law, your health information will be shared with this exchange in order to facilitate the secure exchange of your electronic health information between health care providers and other health care entities for your treatment, payment, or other health care operation purposes. Jai Medical Systems will receive notifications when active patients that we have identified experience certain hospital-related encounters (e.g. admissions, discharges, and transfers). You may "opt-out" and prevent the searching of your health information available through CRISP by calling 1-877-952-7477 or by completing and submitting an opt-out form to CRISP by mail or fax or online at www.crisphealth.org. Jai Medical Systems cannot **submit this opt-out form to CRISP on your behalf should you decide to opt-out**.

- **Other Uses and Disclosures of Health Information Required or Allowed by Law:**
  - **Business Associates:** Jai Medical Systems may disclose health information to those with whom we contract to provide certain services (called business associates) so that they may perform the job we have asked them to do. Jai Medical Systems requires business associates to appropriately safeguard your information.
  - **Required by Law:** Jai Medical Systems may disclose health information when state or federal laws require us to do so. We may also share information with the Department of Health and Human Services if there is a need to verify that we are compliant with privacy laws.
  - **Public Health Activities:** Jai Medical Systems may disclose health information for certain public health activities, including when Jai Medical Systems is required to collect or report information about disease or injury or to report vital statistics to public health authorities.
  - **Health Oversight Activities:** Jai Medical Systems may disclose your health information to health oversight agencies for oversight activities required by law, including audits, inspections, investigations, and licensure actions.
  - **Coroners, Medical Examiners, Funeral Directors, and Organ Donations:** Jai Medical Systems may disclose health information relating to a death to coroners, medical examiners, or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.
  - **Research Purposes:** In certain circumstances, and under supervision of our designated privacy board, Jai Medical Systems may disclose health information to assist medical research.
  - **Avert Threat to Health or Safety:** In order to avoid a serious and imminent threat to health or safety, Jai Medical Systems may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
  - **Abuse and Neglect:** Jai Medical Systems may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence.
  - **Specific Government Functions:** Jai Medical Systems may disclose health information for certain specialized government functions, including those relating to military personnel and veterans, correctional institutions, government benefit programs relating to eligibility and enrollment, national security, and protection of the President.
  - **Families, Friends, or Others Involved in Your Care:** Jai Medical Systems may share your health information with certain people, including family members, friends, and other identified individuals, as it is directly related to their involvement in your care or payment of your care.

Jai Medical Systems may also share health information with certain people, including family members, personal representatives, and entities assisting in disaster relief efforts, to notify them about your location, general condition, or death. Except in emergencies, you have the opportunity to object to these uses and disclosures. If you have a preference on how we share your information, please tell us and we will follow your instructions. If you are not able to tell us your preference, we may share your information if we believe it is in your best interest.

- **Worker's Compensation:** Jai Medical Systems may disclose health information to worker's compensation (or similar) programs that provide benefits for work-related injuries or illnesses without regard to fault as permitted by law.
- **Patient Directories:** The health plan under which you are enrolled does not maintain a directory for disclosure to callers or visitors who ask for you by name. You will not be identified to an unknown caller or visitor without authorization.
- **Lawsuits, Disputes, and Claims:** If you are involved in a lawsuit, a dispute, or a claim, Jai Medical Systems may disclose your health information in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Law Enforcement:** Jai Medical Systems may disclose your health information to a law enforcement official for certain law enforcement purposes, including when required by law or when asked.
- **Special Note:** We will never sell your personal information or use it for certain marketing purposes unless you give us written permission to do so as required by law.

You Have a Right To:

- **Request Restrictions:** You have a right to request a restriction or limitation on the health information that Jai Medical Systems uses or discloses about you for certain purposes. Jai Medical Systems will accommodate your request, if possible, but is not legally required to agree to the requested restriction. If Jai Medical Systems agrees to a restriction, Jai Medical Systems will follow the requested restrictions except in emergency situations.
- **Request Confidential Communications:** You have the right to ask Jai Medical Systems to send your information to another address or by another method. Jai Medical Systems must agree to your request as long as it is reasonably easy for us to do so and if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you.
- **Inspect and Copy:** With certain exceptions, you have a right to see and copy your health information upon your written request usually within 30 days. You may request an electronic copy of your health information that Jai Medical Systems maintains in electronic designated record sets, and we will provide access in the electronic form and format requested if it is readily reproducible in that format. If not, Jai Medical Systems will discuss the issue with you and provide a copy in a mutually agreed upon readable electronic form and format, depending on the information and our capabilities at the time. You may also request that Jai Medical Systems send your information directly to a person you designate if your request is in writing, is signed, and clearly identifies the designated person and an address to send the requested information. If you want copies of your health information (or agree to a summary or explanation of the information), you may be charged a fee for the cost of labor for copying the information (in paper or electronic form), supplies for creating the paper copy or electronic media (if you request that the electronic copy be provided on portable media), postage (if you request that the copy, summary, or explanation be mailed) and preparing an explanation or summary of the information (if you agree). You have a right to choose what portions of your information you want copied and to have prior information on the cost. Jai Medical Systems may deny your request to inspect and copy your information in certain limited circumstances. If the denial is subject to review, you can request that the denial be reviewed. A licensed health care professional that we choose (who was not directly involved in the denial) will review your request and the denial. We will comply with the outcome of the review.

- **Request Amendment:** You may request in writing that Jai Medical Systems correct or add information to your health information record if you provide a reason for the request. Jai Medical Systems may deny the request if it is not in writing or does not include a supporting reason, or if Jai Medical Systems determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; or (3) not permitted to be disclosed. If we deny your request, we will tell you the reason why your request was denied usually within 60 days. In the event of a denial, you may submit a written statement of disagreement. Jai Medical Systems will distribute your statement (or an accurate summary) with future disclosures of the information to which it relates. If Jai Medical Systems approves the request for amendment, Jai Medical Systems will change the health information and inform you, and may tell others that need to know about the change in the health information.
- **Accounting of Disclosures:** You have a right to request a list of the disclosures made of your health information after April 14, 2003, for a period of up to 6 years from the date of the request. Some exceptions include disclosures of information (1) for treatment, payment, and operations purposes, (2) made to you, (3) based on your written authorization, (4) for national security, or (5) to law enforcement officials or correctional facilities with lawful custody of you at the time of the disclosure. There will be no charge for the first request made in each 12 month period. Jai Medical Systems may charge a reasonable, cost-based fee for extra requests.
- **Notice:** You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request at any time.
- **Breach:** You have the right to receive prompt notice of breaches that compromise the privacy or security of your health information, which Jai Medical Systems will send to our last known address for you.
- **Legal Guardian/Representative:** If you have given someone medical power of attorney or if you have a legal guardian, that person is entitled to make decisions about your health information and its use. We will verify that the party has the authority and can make decisions on your behalf before we take any action.

For More Information

This document is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act. If you have questions and would like more information, you may contact the Privacy Officer at 1-888-JAI-1999.

To Report a Problem About Our Privacy Practices

If you believe your privacy rights have been violated, you may file a complaint.

1. You can file a complaint with the Jai Medical Systems Privacy Officer by calling 1-888-JAI-1999.
2. You can file a complaint with the U. S. Department of Health and Human Services Office of Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Jai Medical Systems will take no retaliatory action against you if you make such complaints.

Effective Date: This notice became effective on April 14, 2003. Updated: 11/2013

Attachment P:
Rare and Expensive Case Management Program with List of Qualifying Diagnosis

RARE AND EXPENSIVE CASE MANAGEMENT (REM) PROGRAM

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

Medicaid Benefits and REM Case Management

To qualify for the REM program, the HealthChoice enrollee must have one or more of the diagnoses specified in the Rare and Expensive Disease List below. The enrollee may elect to enroll in the REM Program, or to remain in **[MCO Name]** if the Department agrees that it is medically appropriate. REM participants are eligible for all fee-for-service benefits currently offered to Medicaid-eligible beneficiaries who are not eligible to enroll in MCOs. In addition REM participants may receive additional services which are described in COMAR 10.09.69.

The participant's REM case manager will:

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

Referral and Enrollment Process

Candidates for REM are generally referred by their PCP, specialty providers, MCOs, but may also self-identify. The referral must include a physician's signature and the required supporting documentation for the qualifying diagnosis(es). A registered nurse reviews the medical information: in order to determine the member's eligibility for REM. If the intake nurse determines that there is no qualifying REM diagnosis, the application is sent to the REM physician advisor for a second level review before a denial notice is sent to the member and referral source. If the member does not meet the REM criteria, they will remain enrolled in the MCO.

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

For questions and referral forms call 800-565-8190; forms may be faxed to 410-333-5426 or mailed to:

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

REM Disease List May 20, 2019 Revision			
ICD10	**ICD 10 DESCRIPTION**	**AGE LIMIT**	**GUIDELINES***
B20	Human immunodeficiency virus [HIV] disease	**0-20**	1, 2, 3
C96.0	Multifocal and multisystemic Langerhans-cell histiocytosis	**0-64**	1, 2, 3, 4
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis	**0-64**	1, 2, 3, 4
C96.6	Unifocal Langerhans-cell histiocytosis	**0-64**	1, 2, 3, 4
D61.01	Constitutional (pure) red blood cell aplasia	**0-20**	1, 2-F, 3
D61.09	Other constitutional aplastic anemia	**0-20**	1, 2-F, 3
D66	Hereditary factor VIII deficiency	**0-64**	1, 2-F, 3
D67	Hereditary factor IX deficiency	**0-64**	1, 2-F, 3
D68.0	Von Willebrand's disease	**0-64**	1, 2-F, 3
D68.1	Hereditary factor XI deficiency	**0-64**	1, 2-F, 3
D68.2	Hereditary deficiency of other clotting factors	**0-64**	1, 2-F, 3
E70.0	Classical phenylketonuria	**0-20**	1, 2E, 3
E70.1	Other hyperphenylalaninemias	**0-20**	1, 2E, 3
E70.20	Disorder of tyrosine metabolism, unspecified	**0-20**	1, 2E, 3
E70.21	Tyrosinemia	**0-20**	1, 2E, 3
E70.29	Other disorders of tyrosine metabolism	**0-20**	1, 2E, 3
E70.30	Albinism, unspecified	**0-20**	1, 2E/ or J, 3
E70.40	Disorders of histidine metabolism, unspecified	**0-20**	1, 2E, 3
E70.41	Histidinemia	**0-20**	1, 2E, 3
E70.49	Other disorders of histidine metabolism	**0-20**	1, 2E, 3
E70.5	Disorders of tryptophan metabolism	**0-20**	1, 2E, 3
E70.8	Other disorders of aromatic amino-acid metabolism	**0-20**	1, 2E, 3
E71.0	Maple-syrup-urine disease	**0-20**	1, 2E, 3
E71.110	Isovaleric acidemia	**0-20**	1, 2E, 3
E71.111	3-methylglutaconic aciduria	**0-20**	1, 2E, 3
E71.118	Other branched-chain organic acidurias	**0-20**	1, 2E, 3
E71.120	Methylmalonic acidemia	**0-20**	1, 2E, 3
E71.121	Propionic acidemia	**0-20**	1, 2E, 3
E71.128	Other disorders of propionate metabolism	**0-20**	1, 2E, 3
E71.19	Other disorders of branched-chain amino-acid metabolism	**0-20**	1, 2E, 3
E71.2	Disorder of branched-chain amino-acid metabolism, unspecified	**0-20**	1, 2E, 3
E71.310	Long chain/or very long chain acyl CoA dehydrogenase deficiency	**0-64**	1, 2E, 3
E71.311	Medium chain acyl CoA dehydrogenase deficiency	**0-64**	1, 2E, 3
E71.312	Short chain acyl CoA dehydrogenase deficiency	**0-64**	1, 2E, 3
E71.313	Glutaric aciduria type II	**0-64**	1, 2E, 3
E71.314	Muscle carnitine palmitoyltransferase deficiency	**0-64**	1, 2E, 3
E71.318	Other disorders of fatty-acid oxidation	**0-64**	1, 2E, 3
E71.32	Disorders of ketone metabolism	**0-64**	1, 2E, 3

REM Disease List May 20, 2019 Revision			
ICD10	**ICD 10 DESCRIPTION**	**AGE LIMIT**	**GUIDELINES***
E71.39	Other disorders of fatty-acid metabolism	**0-64**	1, 2E, 3
E71.41	Primary carnitine deficiency	**0-64**	1, 2E, 3
E71.42	Carnitine deficiency due to inborn errors of metabolism	**0-64**	1, 2E, 3
E71.50	Peroxisomal disorder, unspecified	**0-64**	1, 2E, 3
E71.510	Zellweger syndrome	**0-64**	1, 2E, 3
E71.511	Neonatal adrenoleukodystrophy	**0-64**	1, 2E, 3
E71.518	Other disorders of peroxisome biogenesis	**0-64**	1, 2E, 3
E71.520	Childhood cerebral X-linked adrenoleukodystrophy	**0-64**	1, 2E, 3
E71.521	Adolescent X-linked adrenoleukodystrophy	**0-64**	1, 2E, 3
E71.522	Adrenomyeloneuropathy	**0-64**	1, 2E, 3
E71.528	Other X-linked adrenoleukodystrophy	**0-64**	1, 2E, 3
E71.529	X-linked adrenoleukodystrophy, unspecified type	**0-64**	1, 2E, 3
E71.53	Other group 2 peroxisomal disorders	**0-64**	1, 2E, 3
E71.540	Rhizomelic chondrodysplasia punctata	**0-64**	1, 2E, 3
E71.541	Zellweger-like syndrome	**0-64**	1, 2E, 3
E71.542	Other group 3 peroxisomal disorders	**0-64**	1, 2E, 3
E71.548	Other peroxisomal disorders	**0-64**	1, 2E, 3
E72.01	Cystinuria	**0-20**	1, 2E, 3
E72.02	Hartnup's disease	**0-20**	1, 2E, 3
E72.03	Lowe's syndrome	**0-20**	1, 2E, 3
E72.04	Cystinosis	**0-20**	1, 2E, 3
E72.09	Other disorders of amino-acid transport	**0-20**	1, 2E, 3
E72.11	Homocystinuria	**0-20**	1, 2E, 3
E72.12	Methylenetetrahydrofolate reductase deficiency	**0-20**	1, 2E, 3
E72.19	Other disorders of sulfur-bearing amino-acid metabolism	**0-20**	1, 2E, 3
E72.20	Disorder of urea cycle metabolism, unspecified	**0-20**	1, 2E, 3
E72.21	Argininemia	**0-20**	1, 2E, 3
E72.22	Arginosuccinic aciduria	**0-20**	1, 2E, 3
E72.23	Citrullinemia	**0-20**	1, 2E, 3
E72.29	Other disorders of urea cycle metabolism	**0-20**	1, 2E, 3
E72.3	Disorders of lysine and hydroxylysine metabolism	**0-20**	1, 2E, 3
E72.4	Disorders of ornithine metabolism	**0-20**	1, 2E, 3
E72.51	Non-ketotic hyperglycinemia	**0-20**	1, 2E, 3
E72.52	Trimethylaminuria	**0-20**	1, 2E, 3
E72.53	Primary Hyperoxaluria	**0-20**	1, 2E, 3
E72.59	Other disorders of glycine metabolism	**0-20**	1, 2E, 3
E72.81	Disorders of gamma aminobutyric acid metabolism	**0-20**	1, 2E, 3
E72.89	Other specified disorders of amino acid metabolism	**0-20**	1, 2E, 3
E74.00	Glycogen storage disease, unspecified	**0-20**	1, 2E, 3
E74.01	von Gierke disease	**0-20**	1, 2E, 3

REM Disease List May 20, 2019 Revision			
ICD10	**ICD 10 DESCRIPTION**	**AGE LIMIT**	**GUIDELINES***
E74.02	Pompe disease	**0-20**	1, 2E, 3
E74.03	Cori disease	**0-20**	1, 2E, 3
E74.04	McArdle disease	**0-20**	1, 2E, 3
E74.09	Other glycogen storage disease	**0-20**	1, 2E, 3
E74.12	Hereditary fructose intolerance	**0-20**	1, 2E, 3
E74.19	Other disorders of fructose metabolism	**0-20**	1, 2E, 3
E74.21	Galactosemia	**0-20**	1, 2E, 3
E74.29	Other disorders of galactose metabolism	**0-20**	1, 2E, 3
E74.4	Disorders of pyruvate metabolism and gluconeogenesis	**0-20**	1, 2E, 3
E75.00	GM2 gangliosidosis, unspecified	**0-20**	1, 2E, 3, 4
E75.01	Sandhoff disease	**0-20**	1, 2E, 3, 4
E75.02	Tay-Sachs disease	**0-20**	1, 2E, 3, 4
E75.09	Other GM2 gangliosidosis	**0-20**	1, 2E, 3, 4
E75.10	Unspecified gangliosidosis	**0-20**	1, 2E, 3, 4
E75.11	Mucolipidosis IV	**0-20**	1, 2E, 3, 4
E75.19	Other gangliosidosis	**0-20**	1, 2E, 3, 4
E75.21	Fabry (-Anderson) disease	**0-20**	1, 2E, 3
E75.22	Gaucher disease	**0-20**	1, 2E, 3
E75.23	Krabbe disease	**0-20**	1, 2E, 3, 4
E75.240	Niemann-Pick disease type A	**0-20**	1, 2E, 3
E75.241	Niemann-Pick disease type B	**0-20**	1, 2E, 3
E75.242	Niemann-Pick disease type C	**0-20**	1, 2E, 3
E75.243	Niemann-Pick disease type D	**0-20**	1, 2E, 3
E75.248	Other Niemann-Pick disease	**0-20**	1, 2E, 3
E75.25	Metachromatic leukodystrophy	**0-20**	1, 2E, 3, 4
E75.26	Sulfatase deficiency	**0-20**	1, 2E, 3
E75.29	Other sphingolipidosis	**0-20**	1, 2E, 3
E75.3	Sphingolipidosis, unspecified	**0-20**	1, 2E, 3
E75.4	Neuronal ceroid lipofuscinosis	**0-20**	1, 2E, 3, 4
E75.5	Other lipid storage disorders	**0-20**	1, 2E, 3
E76.01	Hurler's syndrome	**0-64**	1, 2E, 3, 4
E76.02	Hurler-Scheie syndrome	**0-64**	1, 2E, 3, 4
E76.03	Scheie's syndrome	**0-64**	1, 2E, 3, 4
E76.1	Mucopolysaccharidosis, type II	**0-64**	1, 2E, 3
E76.210	Morquio A mucopolysaccharidoses	**0-64**	1, 2E, 3
E76.211	Morquio B mucopolysaccharidoses	**0-64**	1, 2E, 3
E76.219	Morquio mucopolysaccharidoses, unspecified	**0-64**	1, 2E, 3
E76.22	Sanfilippo mucopolysaccharidoses	**0-64**	1, 2E, 3
E76.29	Other mucopolysaccharidoses	**0-64**	1, 2E, 3
E76.3	Mucopolysaccharidosis, unspecified	**0-64**	1, 2E, 3
E76.8	Other disorders of glucosaminoglycan metabolism	**0-64**	1, 2E, 3
E77.0	Defects in post-translational mod of lysosomal enzymes	**0-20**	1, 2E, 3
E77.1	Defects in glycoprotein degradation	**0-20**	1, 2E, 3
E77.8	Other disorders of glycoprotein metabolism	**0-20**	1, 2E, 3
E79.1	Lesch-Nyhan syndrome	**0-64**	1, 2E, 3

REM Disease List May 20, 2019 Revision			
ICD10	**ICD 10 DESCRIPTION**	**AGE LIMIT**	**GUIDELINES***
E79.2	Myoadenylate deaminase deficiency	**0-64**	1, 2E, 3
E79.8	Other disorders of purine and pyrimidine metabolism	**0-64**	1, 2E, 3
E79.9	Disorder of purine and pyrimidine metabolism, unspecified	**0-64**	1, 2E, 3
E80.3	Defects of catalase and peroxidase	**0-64**	1, 2E, 3
E84.0	Cystic fibrosis with pulmonary manifestations	**0-64**	1, 2N, 3
E84.11	Meconium ileus in cystic fibrosis	**0-64**	1, 2N, 3
E84.19	Cystic fibrosis with other intestinal manifestations	**0-64**	1, 2N, 3
E84.8	Cystic fibrosis with other manifestations	**0-64**	1, 2N, 3
E84.9	Cystic fibrosis, unspecified	**0-64**	1, 2N, 3
E88.40	Mitochondrial metabolism disorder, unspecified	**0-64**	1, 2E, 3
E88.41	MELAS syndrome	**0-64**	1, 2E, 3
E88.42	MERRF syndrome	**0-64**	1, 2E, 3
E88.49	Other mitochondrial metabolism disorders	**0-64**	1, 2E, 3
E88.89	Other specified metabolic disorders	**0-64**	1, 2E, 3
F84.2	Rett's syndrome	**0-20**	1, 2E/or H, 3, 4
G11.0	Congenital nonprogressive ataxia	**0-20**	1, 2E/or H, 4
G11.1	Early-onset cerebellar ataxia	**0-20**	1, 2E/or H, 4
G11.2	Late-onset cerebellar ataxia	**0-20**	1, 2E/or H, 4
G11.3	Cerebellar ataxia with defective DNA repair	**0-20**	1, 2E/or H, 4
G11.4	Hereditary spastic paraplegia	**0-20**	1, 2E/or H, 4
G11.8	Other hereditary ataxias	**0-20**	1, 2E/or H, 4
G11.9	Hereditary ataxia, unspecified	**0-20**	1, 2E/or H, 4
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]	**0-20**	1, 2E/or H, 3, 4
G12.1	Other inherited spinal muscular atrophy	**0-20**	1, 2E/or H, 3, 4
G12.21	Amyotrophic lateral sclerosis	**0-20**	1, 2E/or H, 3, 4
G12.22	Progressive bulbar palsy	**0-20**	1, 2E/or H, 3, 4
G12.29	Other motor neuron disease	**0-20**	1, 2E/or H, 3, 4
G12.8	Other spinal muscular atrophies and related syndromes	**0-20**	1, 2E/or H, 3, 4
G12.9	Spinal muscular atrophy, unspecified	**0-20**	1, 2E/or H, 3, 4
G24.1	Genetic torsion dystonia	**0-64**	1, 2E/or H, 3, 4
G24.8	Other dystonia	**0-64**	1, 2E/or H, 3, 4
G25.3	Myoclonus	**0-5**	1, 2E/or H, 3, 4
G25.9	Extrapyramidal and movement disorder, unspecified	**0-20**	1, 2E/or H
G31.81	Alpers disease	**0-20**	1, 2E, 3
G31.82	Leigh's disease	**0-20**	1, 2E, 3
G31.9	Degenerative disease of nervous system, unspecified	**0-20**	1, 2H, 4
G32.81	Cerebellar ataxia in diseases classified elsewhere	**0-20**	1, 2H, 4
G37.0	Diffuse sclerosis of central nervous system	**0-64**	1, 2H, 4

REM Disease List May 20, 2019 Revision			
ICD10	**ICD 10 DESCRIPTION**	**AGE LIMIT**	**GUIDELINES***
G37.5	Concentric sclerosis [Balo] of central nervous system	**0-64**	1, 2H, 4
G71.00	Muscular dystrophy, unspecified	**0-64**	1, 2E/or H, 3
G71.01	Duchenne or Becker muscular dystrophy	**0-64**	1, 2E/or H, 3
G71.02	Facioscapulohumeral muscular dystrophy	**0-64**	1, 2E/or H, 3
G71.09	Other specified muscular dystrophies	**0-64**	1, 2E/or H, 3
G71.11	Myotonic muscular dystrophy	**0-64**	1, 2E/or H, 3
G71.2	Congenital myopathies	**0-64**	1, 2E/or H, 3, 4
G80.0	Spastic quadriplegic cerebral palsy	**0-64**	1, 2H/or K/or L
G80.1	Spastic diplegic cerebral palsy	**0-20**	1, 2H/or K/or L
G80.3	Athetoid cerebral palsy	**0-64**	1, 2H/or K/or L
G82.50	Quadriplegia, unspecified	**0-64**	1, 2H/or K/or L,
G82.51	Quadriplegia, C1-C4 complete	**0-64**	1, 2H/or K/or L, 4
G82.52	Quadriplegia, C1-C4 incomplete	**0-64**	1, 2H/or K/or L, 4
G82.53	Quadriplegia, C5-C7 complete	**0-64**	1, 2H/or K/or L, 4
G82.54	Quadriplegia, C5-C7 incomplete	**0-64**	1, 2H/or K/or L, 4
G91.0	Communicating hydrocephalus	**0-20**	1, 2H/or O, 4
G91.1	Obstructive hydrocephalus	**0-20**	1, 2H/or O, 4
I67.5	Moyamoya disease	**0-64**	1, 2H, 4
K91.2	Postsurgical malabsorption, not elsewhere classified	**0-20**	1, 2D/or I/or O, 3
N03.1	Chronic neph syndrome w focal and seg glomerular lesions	**0-20**	1, 2G, 3, 4
N03.2	Chronic nephritic syndrome w diffuse membranous glomrlneph	**0-20**	1, 2G, 3, 4
N03.3	Chronic neph syndrome w diffuse mesangial prolif glomrlneph	**0-20**	1, 2G, 3, 4
N03.4	Chronic neph syndrome w diffuse endocaplry prolif glomrlneph	**0-20**	1, 2G, 3, 4
N03.5	Chronic nephritic syndrome w diffuse mesangiocap glomrlneph	**0-20**	1, 2G, 3, 4
N03.6	Chronic nephritic syndrome with dense deposit disease	**0-20**	1, 2G, 3, 4
N03.7	Chronic nephritic syndrome w diffuse crescentic glomrlneph	**0-20**	1, 2G, 3, 4
N03.8	Chronic nephritic syndrome with other morphologic changes	**0-20**	1, 2G, 3, 4
N03.9	Chronic nephritic syndrome with unsp morphologic changes	**0-20**	1, 2G, 3, 4
N08	Glomerular disorders in diseases classified elsewhere	**0-20**	1, 2G, 3, 4
N18.1	Chronic kidney disease, stage 1	**0-20**	1, 2G, 3, 4
N18.2	Chronic kidney disease, stage 2 (mild)	**0-20**	1, 2G, 3, 4
N18.3	Chronic kidney disease, stage 3 (moderate)	**0-20**	1, 2G, 3, 4
N18.4	Chronic kidney disease, stage 4 (severe)	**0-20**	1, 2G, 3, 4
N18.5	Chronic kidney disease, stage 5	**0-20**	1, 2G, 3, 4
N18.6	End stage renal disease	**0-20**	1, 2G, 3, 4
N18.9	Chronic kidney disease, unspecified	**0-20**	1, 2G, 3, 4
Q01.9	Encephalocele, unspecified	**0-20**	1, 2O, 4

REM Disease List May 20, 2019 Revision			
ICD10	**ICD 10 DESCRIPTION**	**AGE LIMIT**	**GUIDELINES***
Q02	Microcephaly	**0-20**	1, 2H, 4 (Head Circumference X 3)
Q03.0	Malformations of aqueduct of Sylvius	**0-20**	1, 2H, 4
Q03.1	Atresia of foramina of Magendie and Luschka	**0-20**	1, 2H, 4
Q03.8	Other congenital hydrocephalus	**0-20**	1, 2H, 4
Q03.9	Congenital hydrocephalus, unspecified	**0-20**	1, 2H, 4
Q04.3	Other reduction deformities of brain	**0-20**	1, 2H, 4
Q04.5	Megalencephaly	**0-20**	1, 2H, 4
Q04.6	Congenital cerebral cysts	**0-20**	1, 2H, 4
Q04.8	Other specified congenital malformations of brain	**0-20**	1, 2H, 4
Q05.0	Cervical spina bifida with hydrocephalus	**0-64**	1, 2H, 4
Q05.1	Thoracic spina bifida with hydrocephalus	**0-64**	1, 2H, 4
Q05.2	Lumbar spina bifida with hydrocephalus	**0-64**	1, 2H, 4
Q05.3	Sacral spina bifida with hydrocephalus	**0-64**	1, 2H, 4
Q05.4	Unspecified spina bifida with hydrocephalus	**0-64**	1, 2H, 4
Q05.5	Cervical spina bifida without hydrocephalus	**0-64**	1, 2H, 4
Q05.6	Thoracic spina bifida without hydrocephalus	**0-64**	1, 2H, 4
Q05.7	Lumbar spina bifida without hydrocephalus	**0-64**	1, 2H, 4
Q05.8	Sacral spina bifida without hydrocephalus	**0-64**	1, 2H, 4
Q05.9	Spina bifida, unspecified	**0-64**	1, 2H, 4
Q06.0	Amyelia	**0-64**	1, 2H, 4
Q06.1	Hypoplasia and dysplasia of spinal cord	**0-64**	1, 2H, 4
Q06.2	Diastematomyelia	**0-64**	1, 2H, 4
Q06.3	Other congenital cauda equina malformations	**0-64**	1, 2H, 4
Q06.4	Hydromyelia	**0-64**	1, 2H, 4
Q06.8	Other specified congenital malformations of spinal cord	**0-64**	1, 2H, 4
Q07.01	Arnold-Chiari syndrome with spina bifida	**0-64**	1, 2H, 4
Q07.02	Arnold-Chiari syndrome with hydrocephalus	**0-64**	1, 2H, 4
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus	**0-64**	1, 2H, 4
Q30.1	Agenesis and underdevelopment of nose, cleft or absent nose only	**0-5**	1, 2B/or M, 4
Q30.2	Fissured, notched and cleft nose, cleft or absent nose only	**0-5**	1, 2M/or B, 4
Q31.0	Web of larynx	**0-20**	1, 2B/or O, 4
Q31.8	Other congenital malformations of larynx, atresia or agenesis of larynx only	**0-20**	1, 2B/or O, 4
Q32.1	Other congenital malformations of trachea, atresia or agenesis of trachea only	**0-20**	1, 2B/or O, 4
Q32.4	Other congenital malformations of bronchus, atresia or agenesis of bronchus only	**0-20**	1, 2B/or O, 4
Q33.0	Congenital cystic lung	**0-20**	1, 2N, 4
Q33.2	Sequestration of lung	**0-20**	1, 2N, 4
Q33.3	Agenesis of lung	**0-20**	1, 2N, 4
Q33.6	Congenital hypoplasia and dysplasia of lung	**0-20**	1, 2N, 4
Q35.1	Cleft hard palate	**0-20**	1, 2B/or M
Q35.3	Cleft soft palate	**0-20**	1, 2B/or M

REM Disease List May 20, 2019 Revision			
ICD10	**ICD 10 DESCRIPTION**	**AGE LIMIT**	**GUIDELINES***
Q35.5	Cleft hard palate with cleft soft palate	**0-20**	1, 2B/or M
Q35.9	Cleft palate, unspecified	**0-20**	1, 2B/or M
Q37.0	Cleft hard palate with bilateral cleft lip	**0-20**	1, 2B/or M
Q37.1	Cleft hard palate with unilateral cleft lip	**0-20**	1, 2B/or M
Q37.2	Cleft soft palate with bilateral cleft lip	**0-20**	1, 2B/or M
Q37.3	Cleft soft palate with unilateral cleft lip	**0-20**	1, 2B/or M
Q37.4	Cleft hard and soft palate with bilateral cleft lip	**0-20**	1, 2B/or M
Q37.5	Cleft hard and soft palate with unilateral cleft lip	**0-20**	1, 2B/or M
Q37.8	Unspecified cleft palate with bilateral cleft lip	**0-20**	1, 2B/or M
Q37.9	Unspecified cleft palate with unilateral cleft lip	**0-20**	1, 2B/or M
Q39.0	Atresia of esophagus without fistula	**0-3**	1, 2B/or O, 4
Q39.1	Atresia of esophagus with tracheo-esophageal fistula	**0-3**	1, 2B/or O, 4
Q39.2	Congenital tracheo-esophageal fistula without atresia	**0-3**	1, 2B/or O, 4
Q39.3	Congenital stenosis and stricture of esophagus	**0-3**	1, 2B/or O, 4
Q39.4	Esophageal web	**0-3**	1, 2B/or O, 4
Q42.0	Congenital absence, atresia and stenosis of rectum with fistula	**0-5**	1, 2O, 4
Q42.1	Congen absence, atresia and stenosis of rectum without fistula	**0-5**	1, 2O, 4
Q42.2	Congenital absence, atresia and stenosis of anus with fistula	**0-5**	1, 2O, 4
Q42.3	Congenital absence, atresia and stenosis of anus without fistula	**0-5**	1, 2O, 4
Q42.8	Congenital absence, atresia and stenosis of prt lg int	**0-5**	1, 2O, 4
Q42.9	Congen absence, atresia and stenosis of lg int, part unspecified	**0-5**	1, 2O, 4
Q43.1	Hirschsprung's disease	**0-15**	1, 2D/or O, 3, 4
Q44.2	Atresia of bile ducts	**0-20**	1, 2D/or O, 3, 4
Q44.3	Congenital stenosis and stricture of bile ducts	**0-20**	1, 2D/or O, 3, 4
Q44.6	Cystic disease of liver	**0-20**	1, 2D/or O, 3, 4
Q45.0	Agenesis, aplasia and hypoplasia of pancreas	**0-5**	1, 2D, 3, 4
Q45.1	Annular pancreas	**0-5**	1, 2D, 3, 4
Q45.3	Other congenital malformations of pancreas and pancreatic duct	**0-5**	1, 2D, 3, 4
Q45.8	Other specified congenital malformations of digestive system	**0-10**	1, 2D, 3, 4
Q60.1	Renal agenesis, bilateral	**0-20**	1, 2G, 3, 4
Q60.4	Renal hypoplasia, bilateral	**0-20**	1, 2G, 3, 4
Q60.6	Potter's syndrome, with bilateral renal agenesis only	**0-20**	1, 2G, 3, 4
Q61.02	Congenital multiple renal cysts, bilateral only	**0-20**	1, 2G, 3, 4

REM Disease List May 20, 2019 Revision			
ICD10	**ICD 10 DESCRIPTION**	**AGE LIMIT**	**GUIDELINES***
Q61.19	Other polycystic kidney, infantile type, bilateral only	**0-20**	1, 2G, 3, 4
Q61.2	Polycystic kidney, adult type, bilateral only	**0-20**	1, 2G, 3, 4
Q61.3	Polycystic kidney, unspecified, bilateral only	**0-20**	1, 2G, 3, 4
Q61.4	Renal dysplasia, bilateral only	**0-20**	1, 2G, 3, 4
Q61.5	Medullary cystic kidney, bilateral only	**0-20**	1, 2G, 3, 4
Q61.9	Cystic kidney disease, unspecified, bilateral only	**0-20**	1, 2G, 3, 4
Q64.10	Exstrophy of urinary bladder, unspecified	**0-20**	1, 2O/or P, 4
Q64.12	Cloacal extrophy of urinary bladder	**0-20**	1, 2O/or P, 4
Q64.19	Other exstrophy of urinary bladder	**0-20**	1, 2O/or P, 4
Q75.0	Craniosynostosis	**0-20**	1, 2O, 4
Q75.1	Craniofacial dysostosis	**0-20**	1, 2O, 4
Q75.2	Hypertelorism	**0-20**	1, 2O, 4
Q75.4	Mandibulofacial dysostosis	**0-20**	1, 2, 4
Q75.5	Oculomandibular dysostosis	**0-20**	1, 2, 4
Q75.8	Other congenital malformations of skull and face bones	**0-20**	1, 2, 4
Q77.4	Achondroplasia	**0-1**	1, 2, 4
Q77.6	Chondroectodermal dysplasia	**0-1**	1, 2, 4
Q77.8	Other osteochndrdys w defct of growth of tublr bones and spine	**0-1**	1, 2, 4
Q78.0	Osteogenesis imperfecta	**0-20**	1, 2E, 4
Q78.1	Polyostotic fibrous dysplasia	**0-1**	1, 2, 4
Q78.2	Osteopetrosis	**0-1**	1, 2, 4
Q78.3	Progressive diaphyseal dysplasia	**0-1**	1, 2, 4
Q78.4	Enchondromatosis	**0-1**	1, 2, 4
Q78.6	Multiple congenital exostoses	**0-1**	1, 2K, 4
Q78.8	Other specified osteochondrodysplasias	**0-1**	1, 2K, 4
Q78.9	Osteochondrodysplasia, unspecified	**0-1**	1, 2K, 4
Q79.0	Congenital diaphragmatic hernia	**0-1**	1, 2N, 4
Q79.1	Other congenital malformations of diaphragm	**0-1**	1, 2N, 4
Q79.2	Exomphalos	**0-1**	1, 2D/or O, 4
Q79.3	Gastroschisis	**0-1**	1, 2D/or O, 4
Q79.4	Prune belly syndrome	**0-1**	1, 2D/or O, 4
Q79.59	Other congenital malformations of abdominal wall	**0-1**	1, 2D/or O, 4
Q89.7	Multiple congenital malformations, not elsewhere classified	**0-10**	1,2,3,4
R75	Inconclusive laboratory evidence of HIV	**0-12 months**	1, 3
Z21	Asymptomatic human immunodeficiency virus infection status	**0-20**	1, 2, 3
Z99.11	Dependence on respirator [ventilator] status	**1-64**	1, 2N (Vent. Settings documented)
Z99.2	Dependence on renal dialysis (ESRD)	**21-64**	1, 2G, 3, (3 sets of Dialysis Flow Sheets)

*See Guideline Key

RARE AND EXPENSIVE DISEASE LIST
May 20, 2019

*****USE WITH REVISED REM ICD 10 DISEASE LIST TO IDENTIFY THE GUIDELINES REQUIRED TO CONFIRM A REM DIAGNOSIS**

Submit supporting documentation as required in the Guidelines box for the selected REM qualifying ICD 10 code (s).

#1 History and Physical completed within the past 12 months

#2 Specialist Consult note or report confirming diagnosis:

- **A.** Cardiology
- **B.** Ears, Nose, Throat
- **C.** Endocrinology
- **D.** Gastroenterology
- **E.** Genetics
- **F.** Hematology
- **G.** Pediatric Nephrology/Adult Nephrology
- **H.** Neurology/Neurosurgery
- **I.** Nutrition
- **J.** Ophthalmology
- **K**. Orthopedic**s**
- **L**. Physiatrist/PMR
- **M**. Plastic Surgery
- **N**. Pulmonologist
- **O.** Surgery
- **P.** Urology

#3 Laboratory values confirming REM qualifying diagnosis

#4 Imaging Studies confirming diagnosis, for example:

- **A.** CT Scan
- **B.** MRI/MRA
- **C.** Ultra-sound
- **D.** X-rays

Attachment Q:
Local Health ACCU and NEMT
Transportation Contact List

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	www.alleganyhealthdept.com
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	www.aahealth.org
Baltimore City	410-396-4398	410-396-7633	410-649-5000	https://health.baltimorecity.gov
Baltimore County	410-887-2243	410-887-2828	410-887-4381	www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	www.calverthealth.org
Caroline	410-479-8000	410-479-8014	410-479-8189	www.carolinehd.org
Carroll	410-876-2152	410-876-4813	410-876-4941	https://cchd.maryland.gov
Cecil	410-996-5550	410-996-5171	410-996-5130	https://cecilcountyhealth.org
Charles	301-609-6900	301-609-6923	301-609-6760	www.charlescountyhealth.org
Dorchester	410-228-3223	410-901-2426	410-9018167	www.dorchesterhealth.org
Frederick	301-600-1029	301-600-3124	301-600-3124	http://health.frederickcountymd.gov
Garrett	301-334-7777	301-334-7727	301-334-7771	https://garretthealth.org
Harford	410-838-1500	410-638-1671	410-942-7999	https://harfordcountyhealth.com/
Howard	410-313-6300	877-312-6571	410-313-7323	www.howardcountymd.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	www.kenthd.org
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1635	www.montgomerycountymd.gov/hhs/
Prince George's	301-883-7879	301-856-9555	301-856-9550	www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4456	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-4330	www.smchd.org
Somerset	443-523-1700	443-523-1722	443-523-1758	http://somersethealth.org
Talbot	410-819-5600	410-819-5609	410-819-5600	https://health.maryland.gov/talbotcounty/Pages/home.aspx
Washington	240-313-3200	240-313-3264	240-313-3222	https://washcohealth.org
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	https://www.wicomicohealth.org/
Worcester	410-632-1100	410-632-0092	410-629-0614	http://www.worcesterhealth.org/

~~Attachment R:~~

~~Maryland Prenatal Risk Assessment Form (DHMH 4850)~~

Maryland
DEPARTMENT OF HEALTH

Maryland Prenatal Risk Assessment- MDH 4850

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

Provider Demographic Information:

Date of Initial Prenatal Visit/ Form Completed: _____/_____/_____
Provider NPI#: _____ Site NPI#_____
Provider Name: _____Provider Phone Number: _____-_____-_____

Patient Demographic Information:

Patient Last Name:_____First Name:_____ Middle I:_____
DOB: _____/_____/_____ Preferred Pronouns: _____
Social Security Number: _____-_____-_____ Medical Assistance Number (MA): _____
Current Address: Street _____ City_____County _____State_____Zip Code _____
Best Contact Phone Number: ---------- Email: _____
Emergency Contact Name: _____ Contact Phone Number:_____-_____-_____
Communication Barrier: Yes____(Requires an Interpreter Y/N) No _____ Primary Language _____

Insurance Status (at time of prenatal visit):

Uninsured: Y_____N_____	FFS: Y____N_____	Applied for Maryland MA: Y_____N____ Date: _____/_____/_____
Maryland Medicaid: Y_____N____		MCO: _____

Demographics:

Biologic Sex	Male_____Female_____	Other:_____	
Gender Identity	Cisgender: Male _____Female_____	Other: (Patient's own definition) _____	
Race (check all that apply)	Black or African American_____	Asian_____	American Native_____
	Hispanic_____	Native Hawaiian/Pacific Islander ____	Alaska Native_____
	Non Hispanic White_____	Multiracial_____	Unknown_____
Educational Level:	Highest Grade Completed _____	Currently in School: Yes_____ No_____	GED: Yes____No____
Marital Status:	Married_____	Unmarried_____	Unknown_____
	Separated_____	Divorced_____	

Obstetric History Gravida_____Para _____:

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

Entry to Prenatal Care:

OB Date of Initial Visit	_____/_____	Trimester of 1st Prenatal visit	_____1st _____2nd _____3rd
Previous OB Care	_____/_____	LMP___/__/_____	EDC___/__/_____

Risk Factor Assessment:

Psychosocial Risks (Check all that apply)

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

Medical Risks (Check all that apply)

Maternal Age	Age< or = 16 _____ Age> or = 35 _____
Maternal BMI	BMI<18.5 _____ or BMI>30 _____
Sexually Transmitted Infection STI. (GC/Chlamydia/HIV/Hep B/C or Syphilis)	Current/Recently Treated STI: STI Name: _____ STI screening (including Syphilis) completed for current Pregnancy: Y __N _ Past STI Hx: (Syphilis) _____(Herpes)_____
Chronic Disease	Asthma: Y____N_____ Inhaler Rx: Y__N Diabetes Y__N__: If yes then Treatment Medication: _____ Chronic HTN/Heart Disease: Y__N_ Sickle Cell Disease: Y____N_____ Sickle Cell Trait: Y_____N_____ Anemia - HCT<33 or HGB <11: Y___ N _ Lab Result _____ Autoimmune Disorder: Y_____N_____ If yes please name: _____ H/O - Thrombophilias/DVT: If yes please describe: _____
Dental Care	Last Dental visit >1 year. Y_____N_____

Pregnancy Risk Factors (Check all that apply)

Identified obstetric risks	Patient's First Pregnancy: Yes____No____ Covid Vaccinated: Yes ____No_____ Covid Booster Current: Yes ____No_____ Short Interval Pregnancy <9 Months from last birth: Yes_____No_____ Late Entry into Care >14 week: Y___N___ Previous H/O Preterm Labor/Birth: Y____N____ H/O Previous Gestational Diabetes: Y___N___ Current multiple gestation pregnancy: Y____N____ H/O previous LBW Baby: Y_____N_____ H/O previous Fetal Death In Utero >20 weeks: Y ____N___ Previous Pregnancy affected with Preeclampsia/Eclampsia/HELLP Syndrome: Y ___N_____ H/O Cervical Incompetence: Y ____N____ H/O Previous infant affected with congenital defect: Y ___ N____Define: _____

DEFINITIONS (To help complete Risk Assessment)

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

Maryland Prenatal Risk Assessment Form (Instructions for use)

Purpose of Form: Identifies pregnant women who may benefit from local health department Administrative Care Coordination (ACCU) services and serves as the referral mechanism. ACCU services complement medical care and may be provided by nurses, community health and outreach workers and may include education about Medicaid benefits, reinforcement of the medical plan of care, resource linkage and other related services.

Mailing Address (client resides)	Phone Number
Allegany County ACCU 12501 Willowbrook Rd S.E. Cumberland, MD 21502	301-759-5094 Fax: 301-777-2401
Anne Arundel County ACCU 3 Harry S. Truman Parkway, HD8 Annapolis, MD 21401	410-222-7541 Fax: 410-222-4150
Baltimore City ACCU Healthcare Access Maryland 1 N. Charles St., #900 Baltimore, MD 21201	410-949-2357 Fax: 1-888-657-8712
Baltimore County ACCU 6401 York Rd., 3rd Floor Baltimore, MD 21212	410-887-8741 Fax: 410-828-8346
Calvert County ACCU 975 N. Solomon's Island Rd. Prince Frederick, MD 20678	410-535-5400 Fax: 1-833-662-7942
Caroline County ACCU 403 S. 7th St. Denton, MD 21629	410-479-8189 Fax: 410-479-4871
Carroll County ACCU 290 S. Center St. Westminster, MD 21158-0845	410-876-4941 Fax: 410-876-4949
Cecil County ACCU 401 Bow Street Elkton, MD 21921	410-996-5130 Fax: 410-996-0072
Charles County ACCU 4545 Crain Highway White Plains, MD 20695	301-609-6760 Fax: 301-934-7048
Dorchester County ACCU 3 Cedar Street Cambridge, MD 21613	410-901-8167 Fax: 410-228-8976
Frederick County ACCU 350 Montevue Lane Frederick, MD 21702	301-600-3124 Fax: 301-334-7770
Garrett County ACCU 1025 Memorial Drive Oakland, MD 21550	301-334-7695 Fax: 301-334-7771

Instructions: On the initial visit the provider/staff will complete the demographic and assessment sections for pregnant women enrolled in Medicaid at registration and those applying for Medicaid.

- Enter both the provider and site/facility NPI numbers.
- Print clearly; use black pen for all sections.
- If the client does not have a social security number, indicate zeroes.
- Indicate the person completing the form.
- Review for completeness and accuracy.

Faxing and Handling Instructions: **Fax the MPRA to the local health department in the client's county of residence.** To reorder forms call the local ACCU.

Harford County ACCU 2015 Pulaski Highway, Suite E Havre De Grace, MD 21708	410-942-7999 Fax: 443-502-8975
Howard County ACCU 8930 Stanford Blvd. Columbia, MD 21045	410-313-7567 Fax: 410-313-5838
Kent County ACCU 125 S. Lynchburg Street Chestertown, MD 21620	410-778-7035 Fax: 1-844-222-7105
Montgomery County ACCU 1401 Rockville Pike, Suite 2400 Rockville, MD 20852	240-777-1635 Fax: 240-777-4645
Prince George's County ACCU 9314 Piscataway Rd. Clinton, MD 20735	301-856-9550 Fax: 301-856-9607
Queen Anne's County ACCU 206 N. Commerce Street Centreville, MD 21617	443-262-4456 Fax: 443-262-9357
St Mary's County ACCU 21580 Peabody St. Leonardtown, MD 20650	301-475-4330 Fax: 301-309-4117
Somerset County ACCU 8928 Sign Post Road Westover, MD 21871	443-523-1758 Fax: 410-651-2572
Talbot County ACCU 100 S. Hanson Street Easton, MD 21601	410-819-5600 Fax: 410-819-5683
Washington County ACCU 1302 Pennsylvania Avenue Hagerstown, MD 21742	240-313-3229 Fax: 240-313-3222
Wicomico County ACCU 108 E. Main Street Salisbury, MD 21801	410-543-6942 Fax: 410-543-6987
Worcester County ACCU 9730 Healthway Drive Berlin, MD 21811	410-629-0164 Fax: 410-629-0185

Attachment ~~S~~R:
Diabetes Prevention Program

HealthChoice Diabetes Prevention Program

Dear Members,

We wanted to share some exciting news with you! Jai Medical Systems Managed Care Organization, Inc. is offering a Diabetes Prevention (DPP) Program for all qualified members at no cost for you!

What is the Diabetes Prevention Program?

The Diabetes Prevention Program is a lifestyle change program where you will learn, share, and try new things, all while developing new habits and improving your health. Classes are led by a trained lifestyle coach who will help you learn new skills and help you set and meet important health goals. This program provides you with the support and tools to lose weight, create healthy habits, while reducing the risk of diabetes.

What is Diabetes?

Diabetes is a disease in which your blood glucose, or blood sugar levels, are too high.

Am I at risk for developing Diabetes:

1 in 3 U.S adults has prediabetes. You may have prediabetes and be at risk for type 2 diabetes if you:

- Are over 18 years old
- Are overweight or obese
- Have an elevated blood glucose level or a history of gestational diabetes

I may be at risk for Diabetes. What should I do?

Talk to your doctor and take these simple steps:

- Learn more about your risk for Diabetes.
- Start making small steps that can make a big difference in preventing Diabetes.
- Talk with your doctor about blood tests for Diabetes.
- Enroll in one of our **Diabetes Prevention Programs.** You have the choice to participate in one of the two programs:
    - **Online through Omada Health via** http://omadahealth.com/jaimedicalsystems.
    - **Distance Learning/ In-person through Continuum Wellness Center via** www.mycontinuumwellness.com

Call our Customer Service Department at 1-888-JAI-1999 to learn more about the DPP Program.

Attachment ~~T~~S:
Prescription
Prior Authorization Form

ProCare Rx

JAI MEDICAL SYSTEMS

Jai Medical Systems Managed Care Organization, Inc.
Prior Authorization Request Form

Fax completed form to ProCare Rx at 1-866-999-7736 or 1-800-583-6010.
For any questions, please call the Pharmacy Services Department at 1-800-555-8513.

☐ ***Standard*** (Standard review timeframe is **within 24 hours** for complete requests.)

☐ ***Urgent*** (Please only check this box if applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function. Please provide an explanation if the box is checked.)

Member's Name: _____
First **Middle I.** **Last**

Member's ID Number: _____ **Date of Birth:** ____/____/____

Physician: _____ **Contact Person at Office:** _____

Phone Number: _____ **Fax Number:** _____

Requested Medication: _____ **Medication Allergies:** _____

Quantity: _____ **Days' Supply:** _____

Relevant Diagnosis: _____ **ICD Code:** _____

Is this Therapy NEW ☐ **or a CONTINUATION OF THERAPY** ☐ **Start Date:** _____

Previous Medication History: Drug Strength and Dose	**Dates of Therapy**	**Reason for Discontinuing**

☐ Please check box if you are requesting an exception to the 14 day opioid quantity limit due to ongoing therapy.

Rationale for Request

_____

_____

_____

_____

Physician's Signature: _____ **Date:** ____/____/____

In order to expedite processing, please include accurate contact information and signature.
Please also submit lab reports with requests when appropriate, e.g., Culture and Sensitivity; Hemoglobin A1c; Serum Creatinine; CD4; Hematocrit; WBC; etc.

Revised 09/2021