Office of Eligibility Services
Maryland Department of Health and Mental Hygiene

ENROLLMENT AND CAPITATION MODIFICATION MANUAL

December 2011

PREFACE

The Maryland Department of Health and Mental Hygiene (DHMH) Office of Eligibility Services' (OES) HealthChoice Enrollment Unit receives many inquiries from managed care organizations (MCOs) regarding enhanced capitation reimbursement and enrollment. For reimbursement at special capitation rates and for modifications to HealthChoice enrollment, MCOs are required to adhere to DHMH procedures and to use designated forms. In an effort to electronically streamline these required DHMH processes, OES is releasing the *Enrollment and Capitation Modification Manual,* which introduces updated fillable PDF forms that are downloadable from the DHMH website at the following address:

http://dhmh.maryland.gov/mma/MCOupdates/mcomanual.html

The manual contains updated fillable forms for several processes that pertain to either special capitation or enrollment modifications in the following areas: Long Term Care, Newborns, HIV+/AIDS, Changes to Address, Conflicting Information, and the Rare and Expensive Case Management (REM) Program. Additionally, DHMH contact information on the forms is updated. The 1184 Hospital Report of Newborn - and the process for completing this form - is currently being updated and streamlined. Information regarding the new 1184 process will be made available to MCOs when DHMH implements these changes.

MCOs are not permitted to alter or modify the forms and altered forms will not be accepted. Please allow **30 days** for processing. HIV/AIDS capitation adjustments may take longer because of verification procedures.

If you have any questions, please contact our HealthChoice Enrollment Unit during the following times:

HealthChoice Enrollment Unit
(800) 492-5231 (Option 1)
Hours of Operation: 8:00 am to 5:00 pm
(Monday through Friday)

For questions related to HIV/AIDS reimbursement or enrollment contact the Infectious Disease and Environmental Health Administration (IDEHA), Center for HIV Surveillance and Epidemiology (CHSE):

IDEHA/CHSE
410-767-5812 or 410-767-5939

ENROLLMENT AND CAPITATION MODIFICATION MANUAL

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LONG TERM CARE

MCO HEALTHCHOICE DISENROLLMENT FORM

(LONG TERM CARE)

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete this form when the recipient has arrived at the 31st day of an MCO authorized and medically approved Nursing Facility stay.

2. All sections of the form must be completed by the MCO representative who will be the contact for DHMH. The nine-digit MCO provider number must be placed in the appropriate box.

3. If the recipient was admitted to the facility prior to being enrolled into an MCO, the Long Term Care Facility can send or fax the approved 3871 or 257 directly to the HealthChoice Long Term Care Disenrollment Unit.

4. Disenrollment from the MCO will be processed within 3-5 days of receipt of the form by the Department. After the disenrollment is entered into MMIS, the HealthChoice Disenrollment form showing the disenrollment date will be returned to the MCO.

Mail or fax forms to:

HealthChoice Long Term Care Disenrollment Unit
DHMH
201 W. Preston Street
Room L9
Baltimore, Maryland 21201
Phone: 410-767-5321
Fax: 410-333-7141

Note: All data is subject to confirmation by the Department through inspection of DHMH form 3871 or form 257 or other documentation. Please attach the Utilization Control Agent (Delmarva) certification of medical eligibility for LTCF services (from the 3871 or 257).

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

HEALTHCHOICE DISENROLLMENT FORM (LONG TERM CARE)

Recipient M.A. ID:	Social Security Number:	DOB: Month/Day/Year
Last Name:	First Name:	M.I. Sex:
MCO Provider Name:	MCO Provider No:	

Long Term Care Facility Information:

Name: _____

Address: _____

Telephone Number: _____

Admission Date: _____

Anticipated Discharge Date, if any: _____

MCO Official Representative: _____ Date: _____

Title: _____ Phone: _____

Disenrollment Date: _____

(to be determined by Department)

Please attach the Utilization Control Agent (Delmarva Foundation) certification of medical eligibility for LTC services (from the DHMH 3871)

Send or fax to: HealthChoice Long Term Care
Disenrollment Unit
DHMH
201 W. Preston St., Rm L-9
Baltimore, MD 21201
Phone: 410-767-5321
Fax: 410-333-7141

DHMH INTERNAL USE ONLY

Completed by DHMH: _____

Initials: _____

Rev. 5/1/11

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

HEALTHCHOICE DISENROLLMENT FORM (LONG TERM CARE)

Recipient M.A. ID:	Social Security Number:	DOB: Month/Day/Year
01234567890	123-45-6789	01/10/1934
Last Name:	**First Name:**	**M.I.** **Sex:**
Recipient	Robert	A M
MCO Provider Name:	**MCO Provider No:**	
MCO Advantage	678901299	

Long Term Care Facility Information:

Name: Greater Care Nursing Facility

Address: 70 E. West Street, Baltimore, MD 12201

Telephone Number: 410-123-8276

Admission Date: 01-01-2011

Anticipated Discharge Date, if any: 02-28-2011

MCO Official Representative: Jane Representative Date: 01/12/2011

Title: Utilization Manager Phone: 410-123-6543

Disenrollment Date: _____

(to be determined by Department)

Please attach the Utilization Control Agent (Delmarva Foundation) certification of medical eligibility for LTC services (from the DHMH 3871)

Send or fax to: HealthChoice Long Term Care
Disenrollment Unit
DHMH
201 W. Preston St., Rm L-9
Baltimore, MD 21201
Phone: 410-767-5321
Fax: 410-333-7141

DHMH INTERNAL USE ONLY

Completed by DHMH: _____

Initials: _____

Rev. 5/1/11

CODE OF MARYLAND REGULATIONS (COMAR)

10.09.67.12

.12 Benefits — Long-Term Care Facility Services.

A. An MCO shall provide to its enrollees medically necessary services in a chronic hospital, a rehabilitation hospital, or a nursing facility for:

(1) The first 30 continuous days following the enrollee's admission; and

(2) Any days following the first 30 continuous days of an admission until the date the MCO has obtained the Department's determination that the admission is medically necessary as specified in §D of this regulation.

B. Acute care services provided within the first 30 days following an enrollee's admission to a long-term care facility do not constitute a break in calculating the 30 continuous day requirement if the enrollee is discharged from the hospital back to the long-term care facility.

C. The MCO shall reserve nursing facility beds for recipients hospitalized for an acute condition within the first 30 days, not to exceed 15 days per single acute visit.

D. At the time of effecting any nursing facility admission that is expected to result in a length of stay exceeding 30 days, the MCO shall secure a determination by the Department that the admission is medically necessary.

E. The Department shall render a determination with respect to the medical necessity of a stay in a nursing facility as specified in §D of this regulation within 3 business days of receipt of a complete application from the MCO.

F. A determination by the Department that the admission is medically necessary does not relieve the MCO of the obligation to pay for the admission through the day on which the determination is made.

G. An MCO shall use the Department's criteria for determining medical necessity for the days described in §A(1) of this regulation.

For the most recent regulations, please refer to the Code of Maryland Regulations (COMAR) at:

http://www.dsd.state.md.us/comar

Section 2

NEWBORNS

MCO 1184 NEWBORN REPORT FORM

(HEALTHCHOICE)

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete the 1184 Newborn Report form when the MCO is aware that a HealthChoice enrollee has given birth and the MCO has not received an enrollment for the newborn from DHMH. Complete this form after fourteen days only if you have not received the enrollment from DHMH. Please note: the MCO is responsible for the newborn's care from the date of birth.

2. All sections of the 1184 Newborn Report form must be completed by the MCO representative who will be the contact for DHMH.

3. DHMH will establish eligibility through this process and enroll the newborn into the MCO that the mother was enrolled in on the date of the newborn's birth. The newborn will be given thirteen months of eligibility and given a temporary Medical Assistance number. DHMH will also notify the Local Department of Social Services of the birth in order to establish eligibility with a permanent number.

4. A copy of the completed 1184 will be returned to the MCO indicating the Medical Assistance number assigned to the newborn.

Mail or fax forms to: Division of Recipient Eligibility
DHMH
201 W. Preston Street
Room SS7C
Baltimore, Maryland 21201
Phone: 410-767-4944
Fax: 410-333-7012

Note: The current 1184 is in the process of being revised to comply with new Federal guidelines.

[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: _____ **Date Processed: _____** **Processed By: _____**	**Division of Recipient Eligibility** **410-333-7012**		**Division of Recipient Eligibility** **201 West Preston Street** **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.

[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: _____ **Date Processed: _____** **Processed By: _____**	**Division of Recipient Eligibility** **410-333-7012**		**Division of Recipient Eligibility** **201 West Preston Street** **Room SS7C** **Baltimore, Maryland 21201**

Mother's Name: Recipient (Last) Sharon (First) L (M.I.) DOB: 6 / 20 / 88

Mother's Medical Assistance Number: 1 / 2 / 3 / 4 / 5 / 6 / 7 / 0 / 0 / 0 / 0 /

Address: 1522 Wilton Street S.S.#: 2 3 4 / 0 0 / 0 0 0 0

City: Anywhere State: Md Zip Code: 21248

Full Name of Newborn (s)			Date of Birth	Sex		
Last	First	MI	Month/ Day/ Year	M or F	Birth Weight	Race
(A) Recipient	Frederick	M	02 / 15 / 11	M	1249 grams	C
(B)			/ /		grams	

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

(B) ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Name of Mother's MCO: MCO Advantage

Complete Name of Hospital: Beltway Medical Systems

Address: 1022 W. Blakely Street, Anywhere, Maryland 21200 Telephone #: 410-123-6782

Susan Person	/s/	3/2/11
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 X❑

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.

MCO HEALTHCHOICE SPECIAL CAPITATION ENROLLEE

VERY LOW BIRTH WEIGHT NEWBORNS

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete the OPF2005VLBW form for each newborn that weighs less than 1500 grams at birth.

2. The MCO should complete a CMS 1500 for the delivery of the newborn, using an MC001 (city) or an MS001 (state) for the procedure code. Attach the CMS 1500 to the OPF2005VLBW form.

3. All sections of both forms must be completed by the MCO representative who will be the contact for DHMH.

4. Once the weight of the newborn is confirmed by the Vital Statistics Administration, a span will be placed in the recipient's enrollment record for a period of thirteen months beginning with the date of birth of the newborn to allow the special capitation rate to be paid. The OPF2005VLBW form must be received by the Department within nine months of the date of birth or within nine months of the first date of enrollment in the MCO. The CMS 1500 will be forwarded to the Office of Systems, Operations, and Pharmacy for processing.

5. If the HealthChoice Enrollment Unit is unable to process the special capitation rate for any reason, a letter will be sent to the MCO notifying it of the reason for the denial.

6. Any questions about the submission of the OPF2005VLBW form should be directed to the Office of Finance at 410-767-5625, who will be responsible for tracking the requests from MCOs.

Mail or fax forms to: Office of Finance
201 W. Preston Street
Room 216B
Baltimore, Maryland 21201
Attention: Mark Barnstorf
Fax: 410-333-7789

Background:

The capitation rates include separately the cost of HealthChoice very low birth weight (VLBW less than 1500 grams) newborns from delivery through age one. DHMH validates all Maryland deliveries for which HealthChoice MCOs request payment at the VLBW rate. DHMH requests birth data from DHMH – Vital Statistics Administration (VSA) to facilitate the payment of the supplemental kick payment.

These procedures became effective as of January 1, 2005.

State of Maryland
DHMH

FAX FORM IMMEDIATELY TO:
Mark Barnstorf, OF
(410) 333-7789
or
MAIL FORM TO:
Office of Finance
201 West Preston Street
Room 216B
Baltimore, MD 21201

MARYLAND MEDICAL ASSISTANCE PROGRAM

MCO Report of Very Low Birth Weight Newborn

Mother's Name: _____ DOB: _____
Last First M.I.

Mother's Medical Assistance Number: _____

Address: _____ S.S.#: _____

Full Name of Newborn (s) Last	First	M.I.	Birth Date Mo/Day/Yr	Sex M or F	SS Number Applied For Mo/Day/Yr
(A)					
(B)					
(C)					

Complete Name of Hospital: _____

Address: _____ Telephone #: _____

Printed Name of Person Completing Form	Signature of Person Completing Form	Date of Completion
Printed Name of Medical Director	Signature of Medical Director	Date of Completion

Name of Mother's MCO: _____

Birth Weight of Newborn (IN GRAMS): _____

DHMH USE ONLY

Date Received: _____ Confirmed Spans: _____
Date Processed: _____
Processed By: _____

DHMH Use Only: MA Number Assigned:

(A) _____
(B) _____
(C) _____

OPF2005VLBW

State of Maryland
DHMH

FAX FORM IMMEDIATELY TO:
Mark Barnstorf, OF
(410) 333-7789
or
MAIL FORM TO:
Office of Finance
201 West Preston Street
Room 216B
Baltimore, MD 21201

MARYLAND MEDICAL ASSISTANCE PROGRAM
MCO Report of Very Low Birth Weight Newborn

Mother's Name:	Recipient	Sharon	L.	DOB:	6/20/88
	Last	First	M.I.		
Mother's Medical Assistance Number:			12345670000		
Address:	1522 Wilton Street, Anywhere, MD 21200		S.S.#:	234-00-0000	

Full Name of Newborn (s)				Birth Date	Sex	SS Number Applied For
	Last	First	M.I.	Mo/Day/Yr	M or F	Mo/Day/Yr
(A)	Recipient	Frederick	M.	02/15/11	M	02/16/11
(B)						
(C)						

Complete Name of Hospital:	Beltway Medical Systems	
Address:	1022 W. Blakely Street, Anywhere, MD 21200	Telephone #: 410-123-6782

Susan Person	/s/	3/25/11
Printed Name of Person Completing Form	Signature of Person Completing Form	Date of Completion
William Saam, M.D.	/s/	3/25/11
Printed Name of Medical Director	Signature of Medical Director	Date of Completion

Name of Mother's MCO: MCO Advantage

Birth Weight of Newborn (IN GRAMS): 1249

DHMH USE ONLY

Date Received: _____ Confirmed Spans: _____
Date Processed: _____
Processed By: _____

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

OPF2005VLBW

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE LETTER TO MCOS FROM DHMH
UNABLE TO PROCESS TRANSACTION

MCO

Attention:

Recipient:

Dear

Enclosed is a copy of a very low birth weight form that your MCO submitted in order to receive the enhanced capitation rate for this newborn. We are unable to process this transaction for the following reason(s):

_____ DHMH did not receive notification of the low birth weight within the nine-month time frame required under COMAR 10.09.65.19.A.(7).

_____ DHMH has not been notified of the birth of this newborn; therefore, no eligibility has been established in MMIS. Please submit an 1184 to report the birth.

_____ The Division of Vital Records has established that the birth weight of the baby exceeds 1500 grams. If the recorded birth weight is in error, please have the hospital contact the Division of Vital Records to get the birth record corrected.

If you have any further questions or concerns, please contact Ms. Robin Rowell at 410-767-5318 or Ms. Angela Powell at 410-767-5321.

Enclosures

cc: Mr. Mark Barnstorf
Ms. Shirley Maas

Section 3

HIV/AIDS

MCO HEALTHCHOICE SPECIAL CAPITATION ENROLLEE FORM

(HIV+)

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete this form when the MCO becomes aware that a recipient has tested positive for HIV.

2. All sections of the form must be completed by the MCO representative who will be the contact for DHMH.

3. Results of laboratory testing to support the verification method that established a diagnosis of HIV+ must be mailed to the Infectious Disease and Environmental Health Administration (IDEHA), Center for HIV Surveillance and Epidemiology (CHSE):

   IDEHA/CHSE
   500 North Calvert Street, 5th Floor
   Baltimore, Maryland 21202
   Attn: MCO Coordinator

4. Once the diagnosis is confirmed, a permanent span will be placed in the MCO enrollment records. Capitation will be paid beginning the day the diagnosis was confirmed or going back two years from the time the Special Capitation form was received if the diagnosis was greater than two years.

5. Any questions related to HIV can be addressed to IDEHA/CHSE at 410-767-5812 or 410-767-5939.

   Mail forms or hand carry to:

   DHMH - HealthChoice Enrollment Unit
   201 W. Preston Street
   Room L9
   Baltimore, Maryland 21201
   Attention: Rosemary Vranish
   Phone: 410-767-5321

   HIV information is highly confidential and cannot be faxed or emailed.

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

DATE OF DIAGNOSIS: _____ **STATE ID:** _____

SPECIAL CAPITATION ENROLLEE
Notification from MCO of HIV Positive Enrollee

On the basis of the best available medical evidence, the following member has been diagnosed as being **HIV+**

_____ Effective Date of Enrollment: _____
MCO

Name: _____
Last First MI

Address: _____
Street Apt.

_____
City State Zip

Resident County: _____ Medical Assistance Number: _____

Birth Date: _____ Gender: M ☐ F ☐

Race: (check all that apply) ☐ White ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander
☐ Native American/American Indian ☐ Other: (define) _____

Social Security Number: _____

PCP: _____ Phone Number of PCP: _____

Date submitted by MCO: _____

Please mail results of laboratory testing to support verification to:

IDEHA/CHSE, 500 North Calvert Street, 5th Floor, Baltimore, MD 21202
Attention: MCO Coordinator

Please mail or hand carry this completed form to:

DHMH HealthChoice Enrollment Unit, 201 W. Preston Street, Room L-9, Baltimore, MD 21201
Attention: Rosemary Vranish

TO BE COMPLETED BY DHMH:

Diagnosis Verified: _____ *Date Received by DHMH:* _____

Confirmed Spans: _____ *Date Received by IDEHA/CHSE:* _____

Rev: 6/1/11

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

DATE OF DIAGNOSIS: _____ **STATE ID:** _____

SPECIAL CAPITATION ENROLLEE
Notification from MCO of HIV Positive Enrollee

On the basis of the best available medical evidence, the following member has been diagnosed as being **HIV+**

MCO Advantage (MCO) Effective Date of Enrollment: 1/1/11

Name: Recipient (Last) Tom (First) L (MI)

Address: 2109 Atlantic Street (Street) 2A (Apt.)

Anywhere (City) Maryland (State) 21520 (Zip)

Resident County: Allegany Medical Assistance Number: 01236789450

Birth Date: 10/16/66 Gender: M ☒ F ☐

Race: (check all that apply) ☐ White ☐ African American ☐ Hispanic ☒ Asian/Pacific Islander ☐ Native American/American Indian ☐ Other: (define) _____

Social Security Number: 123-70-0000

PCP: Dr. Howard Saam Phone Number of PCP: 301-123-7654

Date submitted by MCO: 2/28/11

Please mail results of laboratory testing to support verification to:

IDEHA/CHSE, 500 North Calvert Street, 5th Floor, Baltimore, MD 21202
Attention: MCO Coordinator

Please mail or hand carry this completed form to:

DHMH HealthChoice Enrollment Unit, 201 W. Preston Street, Room L-9, Baltimore, MD 21201
Attention: Rosemary Vranish

TO BE COMPLETED BY DHMH:

Diagnosis Verified: _____ *Date Received by DHMH:* _____

Confirmed Spans: _____ *Date Received by IDEHA/CHSE:* _____

Rev: 6/1/11

CODE OF MARYLAND REGULATIONS (COMAR)

10.09.65.10

Special Needs Populations — Individuals with HIV/AIDS.

A. An MCO shall meet the standards set forth in this regulation for treating individuals with HIV/AIDS.

B. HIV/AIDS Specialist.

(1) An MCO shall allow an enrollee with HIV/AIDS to choose an HIV/AIDS specialist for treatment and coordination of primary and specialty care.

(2) To qualify as an HIV/AIDS specialist, a health care provider shall be board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties or:

(a) Hold a current, valid, unrevoked, and unsuspended Maryland license or certification as a:

(i) Doctor of medicine;

(ii) Doctor of osteopathy;

(iii) Nurse practitioner; or

(iv) Physician's assistant being supervised by a medical doctor;

(b) Have provided direct, continuous, ongoing care for at least 20 patients with HIV over the past 2 years; and

(c) Have completed one of the following requirements:

(i) If a medical doctor, certified physician's assistant being supervised by a medical doctor, or doctor of osteopathy, at least 30 hours of HIV-related continuing medical education category I credits over the past 2 years;

(ii) If a nurse practitioner, at least 30 hours of HIV-related continuing education units over the past 2 years;

(iii) If a medical doctor, certified physician's assistant being supervised by a medical doctor, doctor of osteopathy, or a nurse practitioner, an accredited training program over the past year; or

COMAR, *10.09.65.10 (continued)*

(iv) If a medical doctor, certified physician's assistant being supervised by a medical doctor, doctor of osteopathy, or a nurse practitioner, has completed the American Academy of HIV Medicine (AAHIVM) credentialing examination.

C. AIDS Case Management Services.

(1) An MCO shall ensure that an enrollee with HIV/AIDS receives case management services that:

(a) Link the enrollee with the full range of available benefits;

(b) Link the enrollee with any additional needed services including:

(i) Mental health services;

(ii) Substance abuse services;

(iii) Medical services;

(iv) Social services;

(v) Financial services;

(vi) Counseling services;

(vii) Educational services;

(viii) Housing services; and

(ix) Other required support services;

(c) Ensure timely and coordinated access to medically necessary levels of care that support continuity of care across the continuum of service providers;

(d) Are performed by licensed physicians, physician assistants, advanced practice nurses, registered nurses, social workers, or other individuals who are appropriately trained, experienced, and supervised by a licensed practitioner; and

(e) Include, but are not limited to:

(i) Initial and ongoing assessment of the enrollee's needs and personal support systems, including the MCO offering an enrollee one face-to-face meeting during the initial assessment and documenting the enrollee's acceptance or declination of the face to face meeting;

(ii) Development of a comprehensive, individualized service plan, using a multidisciplinary approach;

(iii) Coordination of the services required to implement the plan;

(iv) Periodic reevaluation and adaptation of the plan as necessary over the life of the enrollee;

(v) Development of an outreach system for the enrollee and family by which the case manager and primary care provider track services received, clinical outcomes, and the need for additional follow-up; and

(vi) Serving as an effective enrollee advocate to resolve differences between the enrollee and providers of care pertaining to the course or content of therapeutic interventions.

(2) An enrollee diagnosed with HIV/AIDS shall be offered case management services by the MCO at any time after diagnosis. An enrollee who has previously refused these services may request case management from the MCO at any time.

D. Diagnostic Evaluation Service (DES) Assessment.

(1) An MCO shall offer a diagnostic evaluation service (DES) assessment annually and document the enrollee's acceptance or declination.

(2) The DES shall consist of a comprehensive medical and psychosocial assessment.

(3) A DES provider shall use assessment and care plan forms used by the Department for adult and pediatric assessments.

(4) An individual shall select a DES provider from an approved list of sites, and may select a DES provider which is not part of the individual's MCO if so desired.

(5) An MCO and other qualified institutions may become DES providers as provided in COMAR 10.09.32.03C.

E. An individual with HIV/AIDS who is a substance abuser shall receive substance abuse treatment within 24 hours of request.

F. Clinical Trials.

(1) An MCO may refer enrollees who are individuals with HIV/AIDS to facilities or organizations that can provide the enrollees' access to clinical trials.

(2) An MCO shall provide enrollees with HIV/AIDS access to clinical trials in accordance with COMAR 10.09.67.26-1.

MCO HEALTHCHOICE SPECIAL CAPITATION ENROLLEE FORM

(HIV+ Exposed Newborns)

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete this form when the MCO becomes aware that a baby is born to a recipient who has been identified as being HIV+.

2. All sections of the form must be completed by the MCO representative who will be the contact for DHMH.

3. Identify the mother. If the mother is HIV+, a 13 month temporary span, beginning on the date of birth, will be placed in the newborn's enrollment record in order to pay the enhanced capitation rate. The form, along with any attachments, will be forwarded to the Infectious Disease and Environmental Health Administration (IDEHA), Center for HIV Surveillance and Epidemiology (CHSE).

4. Upon receipt of an HIV+ Pediatric less than 13 yrs of age form, in addition to the Newborn Exposure form, with proof of a positive HIV test following CDC guidelines, the newborn will be given a permanent span in order to pay the enhanced capitation rate. MCOs will be notified by the Department when a newborn turns 10 months old so the newborn can be tested.

5. Laboratory reports supporting the pediatric HIV+ diagnosis must be mailed to:

   IDEHA/CHSE
   500 North Calvert Street, 5th Floor
   Baltimore, Maryland 21202
   Attention: MCO Coordinator

6. Any questions related to HIV can be directed to the MCO Coordinator, IDEHA/CHSE, at 410-767-5812 or 410-767-5939.

   Mail forms or hand carry to:

   DHMH - HealthChoice Enrollment Unit
   201 W. Preston Street, Room L9
   Baltimore, Maryland 21201
   Attention: Rosemary Vranish
   Phone: 410-767-5321

   HIV information is highly confidential and cannot be faxed or emailed.

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

STATE ID: _____

SPECIAL CAPITATION ENROLLEE
Notification from MCO of HIV Positive Exposed Newborn

On the basis of the best available medical evidence, the following **Newborn** has been diagnosed as having an **HIV+ defined mother:**

_____ Effective Date of Enrollment: _____
MCO

Newborn Name: _____
Last First MI

Newborn Address: _____
Street Apt.

_____
City State Zip

Newborn Resident County: _____ Medical Assistance Number: _____

Birth Date: _____ Gender: M ☐ F ☐

Newborn Social Security Number: _____

Newborn Race: (check all that apply) ☐ White ☐ African American ☐ Hispanic
☐ Asian/Pacific Islander ☐ Native American/American Indian ☐ Other: (define) _____

PCP: _____ Phone Number of PCP: _____

Birth Information:

Birth Hospital: _____

Mother's Name: _____ Mother's MA No.: _____

Mother's Social Security No.: _____ Mother's Date of Birth: _____

Date Submitted by MCO: _____

Mail or hand carry completed Capitation form to:

DHMH HealthChoice Enrollment Unit, 201 W. Preston Street, Room L-9, Baltimore, MD 21201
Attention: Rosemary Vranish

TO BE COMPLETED BY DHMH:

Diagnosis Verified: _____ *Date Received by DHMH:* _____

Temporary Span: _____

Confirmed Spans: _____ *Date Received by IDEHA/CHSE:* _____

Rev: 6/1/11

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

STATE ID: _____

SPECIAL CAPITATION ENROLLEE
Notification from MCO of HIV Positive Exposed Newborn

On the basis of the best available medical evidence, the following **Newborn** has been diagnosed as having an **HIV+ defined mother:**

MCO Advantage (MCO) — Effective Date of Enrollment: 01/12/11

Newborn Name: Recipient (Last) Jill (First) I. (MI)

Newborn Address: 1207 Atlantic Avenue (Street) 26 (Apt.)

Anywhere (City) Maryland (State) 21200 (Zip)

Newborn Resident County: Allegany — Medical Assistance Number: 01234567890

Birth Date: 01/12/11 — Gender: M ☐ F ☒

Newborn Social Security Number: 123-00-0000

Newborn Race: (check all that apply)
☐ White ☐ African American ☒ Hispanic
☐ Asian/Pacific Islander ☐ Native American/American Indian ☐ Other: (define) _____

PCP: Dr. Howard Saam — Phone Number of PCP: 301-123-7654

Birth Information:
Birth Hospital: Southwest Memorial
Mother's Name: Susan Recipient — Mother's MA No.: 01234567890
Mother's Social Security No.: 123-07-0000 — Mother's Date of Birth: 6/25/82

Date Submitted by MCO: 2/11/11

Mail or hand carry completed Capitation form to:

DHMH HealthChoice Enrollment Unit, 201 W. Preston Street, Room L-9, Baltimore, MD 21201
Attention: Rosemary Vranish

TO BE COMPLETED BY DHMH:

Diagnosis Verified: _____ *Date Received by DHMH:* _____

Temporary Span: _____

Confirmed Spans: _____ *Date Received by IDEHA/CHSE:* _____

Rev: 6/1/11

MCO HEALTHCHOICE SPECIAL CAPITATION ENROLLEE FORM

(HIV+ Pediatric)

(Patients less than 13 years of age at time of diagnosis, excluding newborns)

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete this form when the MCO becomes aware that a recipient who is less than 13 years old has tested positive for HIV.

2. All sections of the form must be completed by the MCO representative who will be the contact for DHMH.

3. According to CDC guidelines, additional information concerning the mother and where the child was born is also necessary.

4. Once the diagnosis is confirmed, a permanent span will be placed in the recipient's enrollment record. Capitation will be paid beginning the day the diagnosis was confirmed or going back two years from the time the Special Capitation form was received if the diagnosis was determined more than two years ago.

5. Results of laboratory testing which follows CDC guidelines to establish a diagnosis of HIV+ must be mailed to the Infectious Disease and Environmental Health Administration (IDEHA), Center for HIV Surveillance and Epidemiology (CHSE):

   IDEHA/CHSE
   500 North Calvert Street, 5th floor
   Baltimore, Maryland 21202
   Attn: MCO Coordinator

6. Any questions related to HIV can be addressed to the MCO Coordinator, IDEHA/CHSE at 410-767-5812 or 410-767-5939.

   Mail Capitation forms or hand carry to:

   DHMH - HealthChoice Enrollment Unit
   201 W. Preston Street, Room L9
   Baltimore, Maryland 21201
   Attention: Rosemary Vranish
   Phone: 410-767-5321

   HIV information is highly confidential and cannot be faxed or emailed.

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

DATE OF DIAGNOSIS: _____ **STATE ID:** _____

SPECIAL CAPITATION ENROLLEE

Notification from MCO of HIV Positive Enrollee

(Pediatric – Patients less than 13 years of age at time of diagnosis, excluding newborns)

On the basis of the best available medical evidence, the following member **(less than 13 years old)** has been diagnosed as being HIV+

_____ Effective Date of Enrollment: _____

MCO

Name: _____

Last First MI

Address: _____

Street Apt.

_____

City State Zip

Resident County: _____ Medical Assistance Number: _____

Birth Date: _____ Gender: M ☐ F ☐

Race: (check all that apply) ☐ White ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander

☐ Native American/American Indian ☐ Other: (define) _____

Social Security Number: _____

PCP: _____ Phone Number of PCP: _____

Date Submitted by MCO: _____

For Recipients less than 13 years of age at the time of diagnosis (excluding Newborns):

Birth Hospital: _____

Mother's Name: _____ Mother's MA No.: _____

Mother's Social Security No.: _____ Mother's Date of Birth: _____

Please mail results of laboratory testing to support verification to:

IDEHA/CHSE, 500 North Calvert Street, 5th Floor, Baltimore, MD 21202 Attn: MCO Coordinator

Forward completed Capitation form to:

DHMH HealthChoice Enrollment Unit, 201 W. Preston Street, Room L-9 Baltimore, MD 21201
Attention: Rosemary Vranish

TO BE COMPLETED BY DHMH:

Diagnosis Verified: _____ *Date Received by DHMH:* _____

Confirmed Spans: _____ *Date Received by IDEHA/CHSE:* _____

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State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

DATE OF DIAGNOSIS: _____ **STATE ID:** _____

SPECIAL CAPITATION ENROLLEE

Notification from MCO of HIV Positive Enrollee

(Pediatric – Patients less than 13 years of age at time of diagnosis, excluding newborns)

On the basis of the best available medical evidence, the following member **(less than 13 years old)** has been diagnosed as being HIV+

MCO Advantage (MCO) Effective Date of Enrollment: 10/21/10

Name: Recipient (Last) Susan (First) E. (MI)

Address: 1021 Atlantic Avenue (Street) 2E (Apt.)

Anywhere (City) Maryland (State) 21502 (Zip)

Resident County: Allegany Medical Assistance Number: 01234567890

Birth Date: 11/07/05 Gender: M ☐ F ☒

Race: (check all that apply) ☐ White ☐ African American ☒ Hispanic ☐ Asian/Pacific Islander ☐ Native American/American Indian ☐ Other: (define) _____

Social Security Number: 123-00-0000

PCP: James Saam, M.D. Phone Number of PCP: 301-123-4567

Date Submitted by MCO: _____

For Recipients less than 13 years of age at the time of diagnosis (excluding Newborns):

Birth Hospital: Southwest Memorial

Mother's Name: Betty Recipient Mother's MA No.: 01234567890

Mother's Social Security No.: 123-02-0000 Mother's Date of Birth: 08/10/85

Please mail results of laboratory testing to support verification to:

IDEHA/CHSE, 500 North Calvert Street, 5th Floor, Baltimore, MD 21202 Attn: MCO Coordinator

Forward completed Capitation form to:

DHMH HealthChoice Enrollment Unit, 201 W. Preston Street, Room L-9 Baltimore, MD 21201
Attention: Rosemary Vranish

TO BE COMPLETED BY DHMH:

Diagnosis Verified: _____ *Date Received by DHMH:* _____

Confirmed Spans: _____ *Date Received by IDEHA/CHSE:* _____

Rev: 6/1/11

MCO HEALTHCHOICE SPECIAL CAPITATION ENROLLEE FORM

(AIDS)

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete this form when the MCO becomes aware that a recipient has tested positive for AIDS.

2. All sections of the form must be completed by the MCO representative who will be the contact for DHMH. **This form must be signed by the MCO Medical Director**.

3. Results of laboratory testing or verification of an opportunistic infection that establishes a diagnosis of AIDS must be mailed to the Infectious Disease and Environmental Health Administration (IDEHA), Center for HIV Surveillance and Epidemiology (CHSE):

   IDEHA/CHSE
   500 North Calvert Street, 5th Floor
   Baltimore, Maryland 21202
   Attn: MCO Coordinator

4. A temporary span for a period of six months will be placed in the MCO enrollment records for the recipient in order to pay the enhanced capitation rate. The form will be forwarded to IDEHA/CHSE.

5. Once the diagnosis is confirmed by IDEHA/CHSE, a permanent span will be placed in the MCO enrollment records. If the diagnosis is not confirmed, the temporary span will be invalidated after a period of nine months and replaced with a regular capitation span. All spans will start at the beginning of the month. Capitation will be paid beginning the month the diagnosis was confirmed or going back two years from the time the Special Capitation form was received if the diagnosis was determined more than two years ago.

6. Any questions related to HIV can be addressed to the IDEHA/CHSE MCO Coordinator at 410-767-5812 or 410-767-5939.

   Mail forms or hand carry to:

   DHMH - HealthChoice Enrollment Unit
   201 W. Preston Street
   Room L9
   Baltimore, Maryland 21201
   Attention: Rosemary Vranish

   AIDS information is highly confidential and cannot be faxed or emailed.

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

DATE OF DIAGNOSIS: _____ **STATE ID:** _____

SPECIAL CAPITATION ENROLLEE
Notification from MCO of AIDS Defined Enrollee

On the basis of the best available medical evidence, the following member has been diagnosed as having **AIDS**:

_____ Effective Date of Enrollment: _____
MCO

Name: _____
Last First MI

Address: _____
Street Apt.

_____
City State Zip

Resident County: _____ Medical Assistance Number: _____

Birth Date: _____ Gender: M ☐ F ☐

Race: (check all that apply) ☐ White ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander
☐ Native American/American Indian ☐ Other: (define) _____

Social Security Number: _____

PCP: _____ Phone Number of PCP: _____

Signature of MCO Medical Director: _____ Date: _____

Please mail or hand carry this completed form to:

DHMH HealthChoice Enrollment Unit, 201 W. Preston Street, Room L-9, Baltimore, MD 21201
Attention: Rosemary Vranish

TO BE COMPLETED BY DHMH:

Diagnosis Verified: _____ *Date Received by DHMH:* _____

Temporary Span: _____

Confirmed Spans: _____ *Date Received by IDEHA/CHSE:* _____

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State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

DATE OF DIAGNOSIS: _____ **STATE ID:** _____

SPECIAL CAPITATION ENROLLEE
Notification from MCO of AIDS Defined Enrollee

On the basis of the best available medical evidence, the following member has been diagnosed as having **AIDS**:

MCO Advantage (MCO) Effective Date of Enrollment: 7/25/10

Name: Recipient (Last) Tom (First) L. (MI)

Address: 2701 Atlantic Avenue (Street) 2B (Apt.)

Anywhere (City) Maryland (State) 21502 (Zip)

Resident County: Allegany Medical Assistance Number: 01234567890

Birth Date: 08/12/67 Gender: M ☒ F ☐

Race: (check all that apply) ☒ White ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander ☐ Native American/American Indian ☐ Other: (define) _____

Social Security Number: 123-02-0000

PCP: Dr. Howard Saam Phone Number of PCP: 301-123-4567

Signature of MCO Medical Director: /s/ Date: 1/21/11

Please mail or hand carry this completed form to:

DHMH HealthChoice Enrollment Unit, 201 W. Preston Street, Room L-9, Baltimore, MD 21201
Attention: Rosemary Vranish

TO BE COMPLETED BY DHMH:

Diagnosis Verified: _____ *Date Received by DHMH:* _____

Temporary Span: _____

Confirmed Spans: _____ *Date Received by IDEHA/CHSE:* _____

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MCO HEALTHCHOICE SPECIAL CAPITATION ENROLLEE

Information Required by the CDC for HIV/AIDS Cases

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete the Patient History form when the MCO becomes aware that a recipient has tested positive for HIV. This is information required by the CDC when filing an HIV case report.

2. All sections of the form must be completed by the MCO representative who will be the contact for the DHMH.

3. Any questions related to HIV/AIDS can be addressed to the MCO Coordinator, IDEHA/CHSE 410-767-5812 or 410-767-5939.

   Mail forms or hand carry to the Infectious Disease and Environmental Health Administration (IDEHA), Center for HIV Surveillance and Epidemiology (CHSE):

   IDEHA/CHSE
   500 North Calvert Street
   5th Floor
   Baltimore, Maryland 21202
   Attention: MCO Coordinator

   HIV information is highly confidential and cannot be faxed or emailed.

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

PATIENT HISTORY
(Information Required by the CDC when filing an HIV/AIDS Case Report)

Name: _____
Last First MI

Medical Assistance Number: _____

Date Submitted by MCO: _____

Please respond to all categories:	Yes	No	Unk
Sex with Male	☐	☐	☐
Sex with Female	☐	☐	☐
Injected Non-Prescription Drugs	☐	☐	☐
Received clotting factor for hemophilia/coagulation disorder	☐	☐	☐

Specify disorder:

☐ Factor VII (Hemophilia A) ☐ Factor IX (Hemophilia B) ☐ Other (Specify): _____

Heterosexual relations with any of the following:	Yes	No	Unk
Intravenous/injection drug user	☐	☐	☐
Bisexual male	☐	☐	☐
Person with hemophilia/coagulation disorder	☐	☐	☐
Transfusion recipient with documented HIV infection	☐	☐	☐
Transplant recipient with documented HIV infection	☐	☐	☐
Person with AIDS or documented HIV infection, risk not specified	☐	☐	☐

	Yes	No	Unk
Received transfusion of blood/blood component (other than clotting factor)	☐	☐	☐

First Last

Month Year Month Year

	Yes	No	Unk
Received Transplant of tissue/organs or artificial insemination (as a primary mode of transmission)	☐	☐	☐

	Yes	No	Unk
Worked in a health-care or clinical laboratory setting (as a primary mode of transmission, documented COPHI)	☐	☐	☐

(Specify Occupation): _____

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State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

PATIENT HISTORY
(Information Required by the CDC when filing an HIV/AIDS Case Report)

Name: Recipient (Last) Jane (First) T (MI)

Medical Assistance Number: 01234567890

Date Submitted by MCO: 2/11/11

Please respond to all categories:	Yes	No	Unk
Sex with Male	☒	☐	☐
Sex with Female	☐	☒	☐
Injected Non-Prescription Drugs	☐	☒	☐
Received clotting factor for hemophilia/coagulation disorder	☐	☒	☐

Specify disorder:

☐ Factor VII (Hemophilia A) ☐ Factor IX (Hemophilia B) ☐ Other (Specify): _____

Heterosexual relations with any of the following:	Yes	No	Unk
Intravenous/injection drug user	☒	☐	☐
Bisexual male	☐	☒	☐
Person with hemophilia/coagulation disorder	☐	☒	☐
Transfusion recipient with documented HIV infection	☐	☒	☐
Transplant recipient with documented HIV infection	☐	☒	☐
Person with AIDS or documented HIV infection, risk not specified	☒	☐	☐

	Yes	No	Unk
Received transfusion of blood/blood component (other than clotting factor)	☐	☒	☐

First Month Year Last Month Year

	Yes	No	Unk
Received Transplant of tissue/organs or artificial insemination (as a primary mode of transmission)	☐	☒	☐

	Yes	No	Unk
Worked in a health-care or clinical laboratory setting (as a primary mode of transmission, documented COPHI)	☐	☒	☐

(Specify Occupation): _____

Section 4

CHANGE OF ADDRESS

MCO RECIPIENT ADDRESS CHANGE FORM

(HEALTHCHOICE)

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete the Address Change form when the MCO receives information that a recipient has changed his address.

2. All sections of the Address Change form must be completed by the MCO representative who will be the contact for DHMH.

3. Make sure the information on the person who reported the address change is completely filled in.

4. DHMH will compare the information with MMIS and CARES. If MMIS is showing the same information, nothing further needs to be done.

5. If CARES has the reported address and MMIS does not, the HealthChoice Enrollment Unit will notify the Division of Recipient Eligibility to change the address in MMIS.

6. If neither MMIS nor CARES are showing the reported information, the HealthChoice Enrollment Unit will send a Conflict Data Report to the Division of Recipient Eligibility. They will then forward the Report to the Local Department of Social Services notifying DSS of the change. Once DSS has verified the change in address and updates CARES, DHMH will receive an electronic transmission to update MMIS.

Mail forms to: HealthChoice Enrollment Unit
DHMH
201 W. Preston Street
Room L9
Baltimore, Maryland 21201
Phone: 410-767-5460

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

MCO HEALTHCHOICE RECIPIENT ADDRESS CHANGE REPORT

Return this form to: HealthChoice, Beneficiary Enrollment Services, Room L-9
201 W. Preston Street, Baltimore, MD 21201

Date: _____

Member Name: _____
Last **First** **M.I.**

Member Medical Assistance #: _____

MCO Name: _____

MCO Representative: _____ **Phone:** _____

Change Reported By: _____ **Relationship:** _____ **Phone:** _____

Correct Address (Per Member): _____

Date Reported: _____

_____

_____

Previous Address: _____

_____

☐ **OUT OF STATE (check box): MUST ATTACH SUPPORTING DOCUMENTATION FOR OUT-OF-STATE ADDRESS**

****

(To be filled out by DHMH and forwarded to DSS)

TO: **Local Department of Social Services** **Date:** _____

RE: **An MCO has notified us of a new address for the Medical Assistance recipient listed above. Please make the appropriate corrections on their record.**

Address on MMIS-II:

_____

_____

_____

CARES Address:

_____

_____

_____

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State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

MCO HEALTHCHOICE RECIPIENT ADDRESS CHANGE REPORT

Return this form to: HealthChoice, Beneficiary Enrollment Services, Room L-9
201 W. Preston Street, Baltimore, MD 21201

Date: 2/15/11

Member Name: Recipient (Last) John (First) T (M.I.)

Member Medical Assistance #: 01234567890

MCO Name: MCO Advantage

MCO Representative: Mary Representative **Phone:** 410-123-4567

Change Reported By: Jane Relative **Relationship:** Mother **Phone:** 410-123-8903

Correct Address (Per Member): 1216 West East Street
Apt. 6
Anywhere, MD 21200

Date Reported: 2/20/11

Previous Address: 921 Second Street, Apt 2B
Anywhere, MD 21200

☐ **OUT OF STATE (check box): MUST ATTACH SUPPORTING DOCUMENTATION FOR OUT-OF-STATE ADDRESS**

****

(To be filled out by DHMH and forwarded to DSS)

TO: **Local Department of Social Services** **Date:** _____

RE: **An MCO has notified us of a new address for the Medical Assistance recipient listed above. Please make the appropriate corrections on their record.**

Address on MMIS-II:

_____

_____

_____

CARES Address:

_____

_____

_____

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MCO RECIPIENT ADDRESS CHANGE FORM

(PAC)

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete this form when the MCO receives information that a recipient has changed his address.

2. All sections of the form must be completed by the MCO representative who will be the contact for DHMH.

3. Make sure the information on the person who reported the address change is completely filled in.

4. The PAC Program will compare the information with the PAC Eligibility Information System and MMIS. If the PAC Eligibility Information System and MMIS are showing the same information, nothing further needs to be done.

5. If the PAC Eligibility Information System has the reported address and MMIS does not, the PAC Program will update MMIS.

6. If neither MMIS nor the PAC Eligibility Information System are showing the reported information, the PAC Program will research further and verify if the reported information is correct. Once the address is verified, the PAC Program will update both the PAC Eligibility Information System and MMIS.

Mail forms to: PAC Eligibility Services Division
P.O. Box 386
Baltimore, Maryland 21203-0386
Phone: 410-767-3980

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

PAC RECIPIENT ADDRESS CHANGE REPORT

Return this form to: PAC Eligibility Services
P.O. Box 386
Baltimore, MD 21203-0386

Date: _____

Member Name: _____
Last **First** **M.I.**

Member Medical Assistance #: _____

MCO Name: _____

MCO Representative: _____ **Phone:** _____

Change Reported By: _____ **Relationship:** _____ **Phone:** _____

Correct Address (Per Member): _____

Date Reported: _____

_____

_____

Previous Address: _____

_____

☐ **OUT OF STATE (check box): MUST ATTACH SUPPORTING DOCUMENTATION FOR OUT-OF-STATE ADDRESS**

****

(If received by DHMH, please forward via inter-office mail to PAC Eligibility Services Division)

TO: **PAC Eligibility Services** **Date:** _____

RE: **An MCO has notified us of a new address for the Medical Assistance recipient listed above. Please make the appropriate corrections on their record.**

Address on MMIS-II:

_____

_____

_____

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State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

PAC RECIPIENT ADDRESS CHANGE REPORT

Return this form to: PAC Eligibility Services
P.O. Box 386
Baltimore, MD 21203-0386

Date: 2/15/11

Member Name: Recipient (**Last**) Jane (**First**) M (**M.I.**)

Member Medical Assistance #: 01234567890

MCO Name: MCO Advantage

MCO Representative: Mary Representative **Phone:** 410-123-4567

Change Reported By: Jane Relative **Relationship:** Mother **Phone:** 410-123-8903

Correct Address (Per Member): 1216 West East Street
Apt 6
Anywhere, MD 21202

Date Reported: 2/20/11

Previous Address: 921 Second Street, Apt. 2B
Anywhere, MD 2121202

☐ **OUT OF STATE (check box): MUST ATTACH SUPPORTING DOCUMENTATION FOR OUT-OF-STATE ADDRESS**

****

(If received by DHMH, please forward via inter-office mail to PAC Eligibility Services Division)

TO: **PAC Eligibility Services** **Date:**

RE: **An MCO has notified us of a new address for the Medical Assistance recipient listed above. Please make the appropriate corrections on their record.**

Address on MMIS-II:

Rev. 5/1/11

Section 5

CONFLICTING DATA

MCO RECIPIENT CONFLICTING DATA REPORT FORM

(HEALTHCHOICE)

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete the Conflicting Data Report form when the MCO receives information that there is a discrepancy in the recipient's demographics.

2. All sections of the Conflicting Data Report form must be completed by the MCO representative who will be the contact for DHMH.

3. DHMH will compare the information with MMIS and CARES. If MMIS is showing the same information, nothing further needs to be done.

4. If CARES has the reported information and MMIS does not, the HealthChoice Enrollment Unit will notify the Division of Recipient Eligibility to change the information in MMIS.

5. If neither MMIS nor CARES are showing the reported information, the HealthChoice Enrollment Unit will send a Conflict Data Report to the Division of Recipient Eligibility. They will then forward the Report to the Local Department of Social Services notifying DSS of the change. Once DSS has verified the change in the information and updates CARES, DHMH will receive an electronic transmission to update MMIS.

   Mail forms to**:** HealthChoice Enrollment Unit
   DHMH
   201 W. Preston Street
   Room L9
   Baltimore, Maryland 21201
   Phone: 410-767-5460

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

MCO RECIPIENT CONFLICTING DATA REPORT

Return this form to: HealthChoice, Beneficiary Enrollment Services, Room L-9
201 W. Preston Street, Baltimore, MD 21201

Date: _____

MCO Name: _____

MCO Representative: _____ Phone: _____

Member Name: _____
Last First M.I.

Member Medical Assistance #: _____

(Check appropriate box in Part I and provide detailed information in Part II)

Part I **This information pertains to:**

Name: ☐ SSN: ☐ DOB: ☐ Gender: ☐ HOH Change: ☐ Phone Number: ☐

Date of Death (include Place of Death): ☐ Incarceration (include Phone #/Name of Facility): ☐

Other: _____

Part II **Reported information needing verification:**

_____

_____

(To be filled out by DHMH and forwarded to DSS)

TO: Local Department of Social Services Date: _____

RE: An MCO has notified us of conflicting data for the Medical Assistance recipient listed above. Please verify the information and make the appropriate corrections on their record.

Information per MMIS-II:

_____

_____

_____

CARES Information:

_____

_____

_____

Rev. 5/1/11

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

MCO RECIPIENT CONFLICTING DATA REPORT

Return this form to: HealthChoice, Beneficiary Enrollment Services, Room L-9
201 W. Preston Street, Baltimore, MD 21201

Date: 2/15/11

MCO Name: MCO Advantage

MCO Representative: Mary Representative Phone: 410-123-7289

Member Name: Recipient (Last) Sarah (First) J. (M.I.)

Member Medical Assistance #: 01234567890

(Check appropriate box in Part I and provide detailed information in Part II)

Part I **This information pertains to:**

Name: ☐ SSN: ☐ DOB: ☒ Gender: ☐ HOH Change: ☐ Phone Number: ☐

Date of Death (include Place of Death): ☐ Incarceration (include Phone #/Name of Facility): ☐

Other:

Part II **Reported information needing verification:**

Recipient's date of birth is 7/28/92

(To be filled out by DHMH and forwarded to DSS)

TO: Local Department of Social Services Date:

RE: An MCO has notified us of conflicting data for the Medical Assistance recipient listed above. Please verify the information and make the appropriate corrections on their record.

Information per MMIS-II:

CARES Information:

MCO RECIPIENT CONFLICTING DATA REPORT FORM

(PAC)

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete the Conflicting Data Report form when the MCO receives information that there is a discrepancy in the recipient's demographics.

2. All sections of the Conflicting Data Report form must be completed by the MCO representative who will be the contact for DHMH.

3. The PAC Program will compare the information with the PAC Eligibility Information System and MMIS. If the PAC Eligibility Information System and MMIS are showing the same information, nothing further needs to be done.

4. If the PAC Eligibility Information System has the reported information and MMIS does not, the PAC Program will update MMIS.

5. If neither MMIS nor the PAC Eligibility Information System are showing the reported information, the PAC Program will research further and verify if the reported information is correct. Once the information is verified, the PAC Program will update both the PAC Eligibility Information System and MMIS.

Mail forms to: PAC Eligibility Services Division
P.O. Box 386
Baltimore, Maryland 21203-0386
Phone: 410-767-3980

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

MCO RECIPIENT CONFLICTING DATA REPORT (PAC)

Return this form to: PAC Eligibility Services, P.O. Box 386
Baltimore, MD 21203-0386

Date: _____

MCO Name: _____

MCO Representative: _____ Phone: _____

Member Name: _____
Last First M.I.

Member Medical Assistance #: _____

(Check appropriate box in Part I and provide detailed information in Part II)

Part I **This information pertains to:**

Name: ☐ SSN: ☐ DOB: ☐ Gender: ☐ HOH Change: ☐ Phone Number: ☐

Date of Death (include Place of Death): ☐ Incarceration (include Phone #/Name of Facility): ☐

Other: _____

Part II **Reported information needing verification:**

_____

_____

(If received by DHMH, please forward via interoffice mail to the PAC Eligibility Services Division)

TO: PAC Eligibility Services Date: _____

RE: An MCO has notified us of conflicting data for the Medical Assistance recipient listed above. Please verify the information and make the appropriate corrections on their record.

Information per MMIS-II:

_____

_____

_____

Rev. 5/1/11

State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

MCO RECIPIENT CONFLICTING DATA REPORT (PAC)

Return this form to: PAC Eligibility Services, P.O. Box 386
Baltimore, MD 21203-0386

Date: 2/15/11

MCO Name: MCO Advantage

MCO Representative: Mary Representative Phone: 410-123-4529

Member Name: Recipient (Last) Jane (First) L. (M.I.)

Member Medical Assistance #: 01234567890

(Check appropriate box in Part I and provide detailed information in Part II)

Part I **This information pertains to:**

Name: ☐ SSN: ☐ DOB: ☒ Gender: ☐ HOH Change: ☐ Phone Number: ☐

Date of Death (include Place of Death): ☐ Incarceration (include Phone #/Name of Facility): ☐

Other:

Part II **Reported information needing verification:**

Recipient's correct date of birth is 4/15/90

(If received by DHMH, please forward via interoffice mail to the PAC Eligibility Services Division)

TO: PAC Eligibility Services Date:

RE: An MCO has notified us of conflicting data for the Medical Assistance recipient listed above. Please verify the information and make the appropriate corrections on their record.

Information per MMIS-II:

Rev. 5/1/11

Section 6

RARE AND EXPENSIVE CASE MANAGEMENT PROGRAM

INSTRUCTIONS FOR COMPLETING THE REM INTAKE/REFERRAL FORM

PLEASE COMPLETE ALL REQUESTED INFORMATION

Page 1 –

Referral Source:
Referral source name, address, telephone number and fax number.

Patient Information:
Patient's first name, middle initial and last name. Patient's Medical Assistance (MA) number.
Patient's complete address, including apartment number, if applicable.
Patient's date of birth, telephone number(s), Sex, and Social Security Number.

Managed Care Organization (MCO) Information. This should include the name of the MCO, the name of a contact person and telephone number at the MCO, if known.

Patient Contact Information:
The person identified may be the patient (if an adult), the parent, guardian, caregiver, significant other etc. Please include the contact person's complete address, telephone number(s) and their relationship to the patient.

Referring Physician Information:
Provide the name of the referring physician. Include the physician's specialty, license number, and telephone number. The referring physician's signature is **required**. Include information about any consulting physicians with their specialties, telephone numbers, and license numbers, if known.

PAGE 2 – Complete patient's name and date of birth at the top of page 2.

Clinical Information:
Provide the primary and secondary diagnoses including the ICD-9 codes. These are necessary to verify eligibility for REM enrollment.

Supporting Information:
This section will require specific information pertaining to each REM diagnosis. The history and physical sections should be completed. Please refer to the guidelines listed on the REM disease list for the recommended medical documentation for each REM eligible diagnosis. Please contact the REM Intake Unit at 1-800-565-8190 if you have any questions.

PLEASE NOTE:
A physician's signature is required at the bottom of page 2. Please fax this completed form and all supporting clinical information to the REM Intake Unit at 410-333-5426.

Or mail to:
Maryland Department of Health & Mental Hygiene
REM Intake Unit
201 W. Preston Street, Room 210
Baltimore, Maryland 21201-2399

For questions, please call the REM Intake Unit at 1-800-565-8190.

Intake & Referral Form

Rare and Expensive Case Management

Questions - Call 1-800-565-8190

Fax (410) 333-5426

Mail or Fax To:

REM Intake Unit
Department of Health & Mental Hygiene (DHMH)
201 W. Preston Street, Room 210
Baltimore, Maryland 21201

DHMH USE ONLY	
CM Agency:	
Date Assigned:	☐ Incomplete ☐ Complete
Screener/Date	Date Received:
County	
Date File Complete:	☐ Approved ☐ Denied Decision Date:

Referral Source: _____	
Address: _____	
Phone	Fax

PATIENT INFORMATION

Patient Name				MA #:
Address				Home Phone
Apt. #		DOB:		Work Phone
City	State	Zip	Sex: **M** **F**	S S #:

MCO	Contact Person
	Phone

Patient Contact		Contact Phone	
Address		Relationship to Patient	
Apt. #	City	State	Zip Code

Referring Physician	**Signature:**	Date:
Name	Phone	
Specialty	License #	
PCP		
Name	Phone	
Specialty	License #	
Consulting Physician		
Name	Phone	
Specialty	License #	

REM Intake & Referral Form

Patient Name: _____ **DOB:** _____

CLINICAL INFORMATION			
Primary Diagnosis		**Secondary Diagnosis**	
ICD-9 Code		ICD-9 Code	
	1		1
	2		2
	3		3
	4		4

SUPPORTING INFORMATION (ATTACH COPIES)
History
Physical
Laboratory/Pathology
Radiology
Consultations
Comments

MD Signature	**Date**

Attachment A

Rare and Expensive Disease List as of December 27, 2010

ICD-9 Code	Disease	Age Group	Guidelines
042.	Symptomatic HIV disease/AIDS (pediatric)	0-20	(A) A child <18 mos. who is known to be HIV seropositive or born to an HIV-infected mother **and:** * Has positive results on two separate specimens (excluding cord blood) from any of the following HIV detection tests: --HIV culture (2 separate cultures) --HIV polymerase chain reaction (PCR) --HIV antigen (p24) N.B. Repeated testing in first 6 mos. of life; optimal timing is age 1 month and age 4-6 mos. **or** * Meets criteria for Acquired Immunodeficiency Syndrome (AIDS) diagnosis based on the 1987 AIDS surveillance case definition
V08	Asymptomatic HIV status (pediatric)	0-20	(B) A child >18 mos. born to an HIV-infected mother or any child infected by blood, blood products, or other known modes of transmission (e.g., sexual contact) who: * Is HIV-antibody positive by confirmatory Western blot or immunofluorescense assay (IFA) **or** * Meets any of the criteria in (A) above
795.71	Infant with inconclusive HIV result	0-12 months	(E) A child who does not meet the criteria above who: * Is HIV seropositive by ELISA and confirmatory Western blot or IFA and is 18 mos. or less in age at the time of the test **or** * Has unknown antibody status, but was born to a mother known to be infected with HIV
270.0	Disturbances of amino-acid transport Cystinosis Cystinuria Hartnup disease	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
270.1	Phenylketonuria - PKU	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required. Lab test: high plasma phenylalanine and normal/low tyrosine
270.2	Other disturbances of aromatic-acid metabolism	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
270.3	Disturbances of branched-chain amino-acid metabolism	0-20	
270.4	Disturbances of sulphur-bearing amino-acid metabolism	0-20	
270.5	Disturbances of histidine metabolism Carnosinemia Histidinemia Hyperhistidinemia Imidazole aminoaciduria	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.

Attachment A

Rare and Expensive Disease List as of December 27, 2010

ICD-9 Code	Disease	Age Group	Guidelines
270.6	Disorders of urea cycle metabolism	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
270.7	Other disturbances of straight-chain amino-acid Glucoglycinuria Glycinemia (with methylmalonic acidemia) Hyperglycinemia Hyperlysinemia Pipecolic acidemia Saccharopinuria Other disturbances of metabolism of glycine, threonine, serine, glutamine, and lysine	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
270.8	Other specified disorders of amino-acid metabolism Alaninemia Ethanolaminuria Glycoprolinuria Hydroxyprolinemia Hyperprolinemia Iminoacidopathy Prolinemia Prolinuria Sarcosinemia	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.
271.0	Glycogenosis	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.
271.1	Galactosemia	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.
271.2	Hereditary fructose intolerance	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.
272.7	Lipidoses	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.
277.00	Cystic fibrosis without ileus.	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.
277.01	Cystic fibrosis with ileus.	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.
277.02	Cystic fibrosis with pulmonary manifestations	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.
277.03	Cystic fibrosis with gastrointestinal manifestations	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.

Attachment A

Rare and Expensive Disease List as of December 27, 2010

ICD-9 Code	Disease	Age Group	Guidelines
277.09	Cystic fibrosis with other manifestations	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.
277.2	Other disorders of purine and pyrimidine metabolism	0-64	Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required. Demonstration of deficient enzyme such as: alpha-L-Idurondase, Iduronosulfate sulfatase, Heparan sulfate sulfatase, N-Acetyl-alpha-D-glucosaminidase, Arylsulfatase B, Beta-Glucuronidase, Beta-Galactosidase, N-Aacetylhexosaminidase-6-SO4 sulfatase.
277.5	Mucopolysaccharidosis	0-64	
277.81	Primary Carnitine deficiency	0-64	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub specialist consultation note may be required.
277.82	Carnitine deficiency due to inborn errors of metabolism	0-64	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub specialist consultation note may be required.
277.89	Other specified disorders of metabolism	0-64	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub specialist consultation note may be required.
284.01	Constitutional red blood cell asplasia	0-20	Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.
284.09	Other constitutional aplastic anemia	0-20	
286.0	Congenital factor VIII disorder	0-64	
286.1	Congenital factor IX disorder	0-64	
286.2	Congenital factor XI deficiency	0-64	
286.3	Congenital deficiency of other clotting factors	0-64	
286.4	von Willebrand's disease	0-64	
330.0	Leukodystrophy	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
330.1	Cerebral lipidoses	0-20	
330.2	Cerebral degenerations in generalized lipidoses	0-20	
330.3	Cerebral degeneration of childhood in other diseases classified	0-20	
330.8	Other specified cerebral degeneration in childhood	0-20	
330.9	Unspecified cerebral degeneration in childhood	0-20	
331.3	Communicating hydrocephalus	0-20	Clinical history and physical exam; imaging studies supporting diagnosis. Sub specialist consultation note may be required.
331.4	Obstructive hydrocephalus	0-20	
333.2	Myoclonus	0-5	Clinical history and physical exam. Sub specialist consultation note may be required.

Attachment A

Rare and Expensive Disease List as of December 27, 2010

ICD-9 Code	Disease	Age Group	Guidelines
333.6	Idiopathic torsion dystonia	0-64	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub specialist consultation note may be required.
333.7	Symptomatic torsion dystonia	0-64	
333.90	Unspecified extrapyramidal disease and abnormal movement disorder	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Subspecialist consultation note may be required.
334.0	Friedreich's ataxia	0-20	Clinical history and physical exam. Neurology consultation note.
334.1	Hereditary spastic paraplegia	0-20	
334.2	Primary cerebellar degeneration	0-20	
334.3	Cerebellar ataxia NOS	0-20	
334.4	Cerebellar ataxia in other diseases	0-20	
334.8	Other spinocerebellar diseases NEC	0-20	
334.9	Spinocerebellar disease NOS	0-20	
335.0	Werdnig-Hoffmann disease	0-20	Clinical history and physical exam. Neurology consultation note.
335.10	Spinal muscular atrophy unspecified	0-20	
335.11	Kugelberg-Welander disease	0-20	
335.19	Spinal muscular atrophy NEC	0-20	
335.20	Amyotrophic lateral sclerosis	0-20	
335.21	Progressive muscular atrophy	0-20	
335.22	Progressive bulbar palsy	0-20	
335.23	Pseudobulbar palsy	0-20	
335.24	Primary lateral sclerosis	0-20	
335.29	Motor neuron disease NEC	0-20	
335.8	Anterior horn disease NEC	0-20	
335.9	Anterior horn disease NOS	0-20	
341.1	Schilder's disease	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
343.0	Diplegic infantile cerebral palsy	0-20	Clinical history and physical exam. Neurology consultation note may be required.
343.2	Quadriplegic infantile cerebral palsy	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
344.00	Quadriplegia, unspecified	0-64	
344.01	Quadriplegia, C1-C4, complete	0-64	
344.02	Quadriplegia, C1-C4, incomplete	0-64	
344.03	Quadriplegia, C5-C7, complete	0-64	

Attachment A

Rare and Expensive Disease List as of December 27, 2010

ICD-9 Code	Disease	Age Group	Guidelines
344.04	Quadriplegia, C5-C7, incomplete	0-64	
344.09	Quadriplegia, Other	0-64	
359.0	Congenital hereditary muscular dystrophy	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
359.1	Hereditary progressive muscular dystrophy	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
359.21	Myotonic muscular dystrophy (Steinert's only)	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
437.5	Moyamoya disease	0-64	Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.
579.3	Short gut syndrome	0-20	Clinical history and imaging studies supporting diagnosis. Gastrointestinal sub-specialist consultation note may be required.
582.0	Chronic glomerulonephritis with lesion of proliferative glomerulonephritis	0-20	Clinical history, laboratory evidence of renal disease. Nephrology sub-specialist consultation note may be required.
582.1	Chronic glomerulonephritis with lesion of membranous glomerulonephritis	0-20	
582.2	Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis	0-20	
582.4	Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis	0-20	
582.81	Chronic glomerulonephritis in diseases classified elsewhere	0-20	
582.89	Other Chronic glomerulonephritis with lesion of exudative nephritis interstitial (diffuse) (focal) nephritis	0-20	
582.9	With unspecified pathological lesion in kidney Glomerulonephritis: NOS specified as chronic hemorrhagic specified as chronic Nephritis specified as chronic Nephropathy specified as chronic	0-20	
585.1	Chronic kidney disease, Stage I (diagnosed by a pediatric nephrologists)	0-20	
585.2	Chronic kidney disease, Stage II (mild) (diagnosed by a pediatric nephrologists)	0-20	
585.3	Chronic kidney disease, Stage III (moderate) (diagnosed by a pediatric nephrologists)	0-20	

Attachment A

Rare and Expensive Disease List as of December 27, 2010

ICD-9 Code	Disease	Age Group	Guidelines
585.4	Chronic kidney disease, Stage IV (severe) (diagnosed by a pediatric nephrologists)	0-20	
585.5	Chronic kidney disease, Stage V (diagnosed by a pediatric nephrologists)	0-20	
585.6	End stage renal disease (diagnosed by a pediatric nephrologists)	0-20	
585.9	Chronic kidney disease, unspecified (diagnosed by a pediatric nephrologists)	0-20	
585.6, V45.11	Chronic kidney disease with dialysis	21-64	Clinical history, laboratory, evidence of renal disease. Nephrology sub-specialist consultation note may be required.
741.00	Spina bifida with hydrocephalus NOS	0-64	Clinical history and physical exam, imaging studies supporting diagnosis. Sub-specialist consultation may be required.
741.01	Spina bifida with hydrocephalus cervical region	0-64	
741.02	Spina bifida with hydrocephalus dorsal region	0-64	
741.03	Spina bifida with hydrocephalus lumbar region	0-64	
741.90	Spina bifida unspecified region	0-64	
741.91	Spina bifida cervical region	0-64	
741.92	Spina bifida dorsal region	0-64	
741.93	Spina bifida lumbar region	0-64	
742.0	Encephalocele Encephalocystocele Encephalomyelocele Hydroencephalocele Hydromeningocele, cranial Meningocele, cerebral Menigoencephalocele	0-20	Clinical history and physical examination, radiographic or other neuroimaging studies. Neurology or neurosurgery consultation note may be required.
742.1	Microcephalus Hydromicrocephaly Micrencephaly	0-20	Clinical history and physical examination, radiographic or other neuroimaging studies. Neurology or neurosurgery consultation note may be required.
742.3	Congenital hydrocephalus	0-20	
742.4	Other specified anomalies of brain	0-20	
742.51	Other specified anomalies of the spinal cord Diastematomyelia	0-64	
742.53	Other specified anomalies of the spinal cord Hydromyelia	0-64	

Attachment A

Rare and Expensive Disease List as of December 27, 2010

ICD-9 Code	Disease	Age Group	Guidelines
742.59	Other specified anomalies of spinal cord Amyelia Congenital anomaly of spinal meninges Myelodysplasia Hypoplasia of spinal cord	0-64	
748.1	Nose anomaly - cleft or absent nose ONLY	0-5	Clinical history and physical examination. Radiographic or other imaging studies and specialist consultation note (ENT, plastic surgery) may be required.
748.2	Web of larynx	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.
748.3	Laryngotracheal anomaly NEC-Atresia or agenesis of larynx, bronchus, trachea, only	0-20	
748.4	Congenital cystic lung	0-20	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.
748.5	Agenesis, hypoplasia and dysplasia of lung	0-20	
749.00	Cleft palate NOS	0-20	Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.
749.01	Unilateral cleft palate complete	0-20	
749.02	Unilateral cleft palate incomplete	0-20	
749.03	Bilateral cleft palate complete	0-20	
749.04	Bilateral cleft palate incomplete	0-20	
749.20	Cleft palate and cleft lip NOS	0-20	
749.21	Unilateral cleft palate with cleft lip complete	0-20	
749.22	Unilateral cleft palate with cleft lip incomplete	0-20	
749.23	Bilateral cleft palate with cleft lip complete	0-20	
749.24	Bilateral cleft palate with cleft lip incomplete	0-20	
749.25	Cleft palate with cleft lip NEC	0-20	
750.3	Congenital tracheoesophageal fistula, esophageal atresia and stenosis	0-3	Clinical history and physical exam; imaging studies supporting diagnosis. Sub-specialist consultation note may be required.
751.2	Atresia large intestine	0-5	Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.
751.3	Hirschsprung's disease	0-15	
751.61	Biliary atresia	0-20	
751.62	Congenital cystic liver disease	0-20	
751.7	Pancreas anomalies	0-5	
751.8	Other specified anomalies of digestive system NOS	0-10	

Attachment A

Rare and Expensive Disease List as of December 27, 2010

ICD-9 Code	Disease	Age Group	Guidelines
753.0	Renal agenesis and dysgenesis, **bilateral only** Atrophy of kidney: congenital infantile Congenital absence of kidney(s) Hypoplasia of kidney(s)	0-20	Clinical history, physical examination, radiographic or other imaging studies. Sub-specialist consultation note may be required.
753.10	Cystic kidney disease, **bilateral only**	0-20	
753.12	Polycystic kidney, unspecified type, **bilateral only**	0-20	
753.13	Polycystic kidney, autosomal dominant, **bilateral only**	0-20	
753.14	Polycystic kidney, autosomal recessive, **bilateral only**	0-20	
753.15	Renal dysplasia, **bilateral only**	0-20	
753.16	Medullary cystic kidney, **bilateral only**	0-20	
753.17	Medullary sponge kidney, **bilateral only**	0-20	
753.5	Exstrophy of urinary bladder	0-20	
756.0	Musculoskeletal--skull and face bones Absence of skull bones Acrocephaly Congenital deformity of forehead Craniosynostosis Crouzon's disease Hypertelorism Imperfect fusion of skull Oxycephaly Platybasia Premature closure of cranial sutures Tower skull Trigonocephaly	0-20	Clinical history, physical examination, radiographic or other imaging studies supporting diagnosis. Sub-specialist consultation note may be required.
756.4	Chondrodystrophy	0-1	
756.50	Osteodystrophy NOS	0-1	
756.51	Osteogenesis imperfecta	0-20	Clinical history, physical exam; imaging studies supporting diagnosis. Sub-specialist consultation note may be required
756.52	Osteopetrosis	0-1	Clinical history, physical examination, imaging studies supporting diagnosis. Sub-specialist consultation note may be required.
756.53	Osteopoikilosis	0-1	
756.54	Polyostotic fibrous dysplasia of bone	0-1	
756.55	Chondroectodermal dysplasia	0-1	
756.56	Multiple epiphyseal dysplasia	0-1	

Attachment A

Rare and Expensive Disease List as of December 27, 2010

ICD-9 Code	Disease	Age Group	Guidelines
756.59	Osteodystrophy NEC	0-1	
756.6	Anomalies of diaphragm	0-1	
756.70	Anomaly of abdominal wall	0-1	
756.71	Prune belly syndrome	0-1	
756.72	Omphalocele	0-1	
756.73	Gastrochisis	0-1	
756.79	Other congenital anomalies of abdominal wall	0-1	
759.7	Multiple congenital anomalies NOS	0-10	Clinical history, physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.
V46.1	Dependence on respirator	1-64	Clinical history and physical exam. Sub-specialist consultation note required.