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
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Section I

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).
HEALTHCHOICE DISENROLLMENT FORM
(LONG TERM CARE)

<table>
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<tr>
<th>Recipient M.A. ID:</th>
<th>Social Security Number:</th>
<th>DOB: Month/Day/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td>First Name:</td>
<td>M.I. Sex:</td>
</tr>
<tr>
<td>MCO Provider Name:</td>
<td>MCO Provider No:</td>
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**Long Term Care Facility Information:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Telephone Number:</th>
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<tbody>
<tr>
<td>Admision Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticipated Discharge Date, if any:</td>
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<table>
<thead>
<tr>
<th>MCO Official Representative:</th>
<th>Date:</th>
<th>Title:</th>
<th>Phone:</th>
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</table>

**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
HEALTHCHOICE DISENROLLMENT FORM  
(LONG TERM CARE)

<table>
<thead>
<tr>
<th>Recipient M.A. ID:</th>
<th>Social Security Number:</th>
<th>DOB: Month/Day/Year</th>
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</thead>
<tbody>
<tr>
<td>01234567890</td>
<td>123-45-6789</td>
<td>01/10/1934</td>
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<table>
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<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>M.I.</th>
<th>Sex:</th>
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<tbody>
<tr>
<td>Recipient</td>
<td>Robert</td>
<td>M</td>
<td>M</td>
</tr>
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<table>
<thead>
<tr>
<th>MCO Provider Name:</th>
<th>MCO Provider No:</th>
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<tr>
<td>MCO Advantage</td>
<td>678901299</td>
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**Long Term Care Facility Information:**

<table>
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<tr>
<th>Name:</th>
<th>Greater Care Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>70 E. West Street, Baltimore, MD 12201</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>410-123-8276</td>
</tr>
<tr>
<td>Admission Date:</td>
<td>01-01-2011</td>
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<td>Anticipated Discharge Date:</td>
<td>02-28-2011</td>
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<table>
<thead>
<tr>
<th>MCO Official Representative:</th>
<th>Jane Representative</th>
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<tbody>
<tr>
<td>Date:</td>
<td>01/12/2011</td>
</tr>
<tr>
<td>Title:</td>
<td>Utilization Manager</td>
</tr>
<tr>
<td>Phone:</td>
<td>410-123-6543</td>
</tr>
</tbody>
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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

SAMPLE
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.
**Mother’s Name:** ___________________________________________________________________  DOB: __/__/__

(Last) (First) (M.I.)

**Mother’s Medical Assistance Number:** ____________

**Address:** ____________________________________________________  S.S.#: __ __ / __ / __ __ __ __

**City:** ___________________________________  **State:** _____________  **Zip Code:** ____________________

---

<table>
<thead>
<tr>
<th>Full Name of Newborn (s)</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Birth Weight</th>
<th>Race</th>
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<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>MI</td>
<td>Month/ Day/ Year</td>
<td>M or F</td>
</tr>
<tr>
<td>(A)</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>M or F</td>
</tr>
<tr>
<td>(B)</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td>M or F</td>
</tr>
</tbody>
</table>

**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.
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
**MARYLAND MEDICAL ASSISTANCE PROGRAM**

**HOSPITAL REPORT OF NEWBORNS**

<table>
<thead>
<tr>
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<th>FAX FORM IMMEDIATELY TO:</th>
<th>OR</th>
<th>MAIL FORM TO:</th>
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<td>Date Received:</td>
<td>Division of Recipient Eligibility</td>
<td>410-333-7012</td>
<td>Division of Recipient Eligibility</td>
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<tr>
<td>Date Processed:</td>
<td></td>
<td></td>
<td>201 West Preston Street</td>
</tr>
<tr>
<td>Processed By:</td>
<td></td>
<td></td>
<td>Room SS7C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baltimore, Maryland 21201</td>
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Mother’s Name: Sharon (Last) (First) (M.I.)
Mother’s Medical Assistance Number: 1 2 3 4 5 6 7 0 0 0 / 0
Address: 1522 Wilton Street
City: Anywhere
State: Md
Zip Code: 21248

<table>
<thead>
<tr>
<th>Full Name of Newborn (s)</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Birth Weight</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>MI</td>
<td>Month/ Day/ Year</td>
<td>M or F</td>
</tr>
<tr>
<td>(A) Recipient</td>
<td>Frederick</td>
<td>M</td>
<td>02 / 15 / 11</td>
<td>M</td>
</tr>
<tr>
<td>(B)</td>
<td></td>
<td></td>
<td></td>
<td>C</td>
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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/ Printed Name of Person Completing Form /s/ Signature of Person Completing Form Date of Completion 3/2/11

**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.
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.
# MARYLAND MEDICAL ASSISTANCE PROGRAM

## MCO Report of Very Low Birth Weight Newborn

<table>
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<tr>
<th>Mother’s Name:</th>
<th>DOB:</th>
<th>Last</th>
<th>First</th>
<th>M.I.</th>
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<tbody>
<tr>
<td>Mother’s Medical Assistance Number:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>S.S.#:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Full Name of Newborn (s)

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>M.I.</th>
<th>Birth Date</th>
<th>Sex</th>
<th>SS Number Applied For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo/Day/Yr</td>
<td>M or F</td>
<td>Mo/Day/Yr</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(A)

(B)

(C)

### Complete Name of Hospital:

<table>
<thead>
<tr>
<th>Address:</th>
<th>Telephone #:</th>
</tr>
</thead>
</table>

### 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
# MARYLAND MEDICAL ASSISTANCE PROGRAM

## MCO Report of Very Low Birth Weight Newborn

### Mother’s Information
- **Name:** Recipient Sharon L.
- **DOB:** 6/20/88
- **Medical Assistance Number:** 12345670000
- **Address:** 1522 Wilton Street, Anywhere, MD 21200
- **S.S.#:** 234-00-0000

### Newborn Information
- **Name:** Recipient Frederick M.
- **Birth Date:** 02/15/11
- **Sex:** M
- **SS Number Applied For:**
- **Birth Weight:** 1249

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

### Completion Details
- **Person Completing Form:** Susan Person
- **Signature:** /s/
- **Date of Completion:** 3/25/11
- **Medical Director:** William Saam, M.D.
- **Signature:** /s/
- **Date of Completion:** 3/25/11

### MCO Information
- **Name of MCO:** MCO Advantage

### DHMH Use Only
- **MA Number Assigned:** OPF2005VLBW
HEALTH INSURANCE CLAIM FORM

1. MEDICARE [ ] MEDICAID [ ] TRICARE [ ] CHAMPVA [ ] GROUP [ ] SELF-INSURED [ ] OTHER [ ]

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

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

4. INSURED'S I.D. NUMBER

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

6. PATIENT RELATIONSHIP TO INSURED
   Self  Spouse  Child  Other

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

8. PATIENT STATUS
   Single  Married  Divorced  Widowed  Other

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

10. OTHER INSURED'S POLICY OR GROUP NUMBER

11. INSURED'S DATE OF BIRTH
    MM   DD   YY
    M     F

12. INSURED'S DATE OF DEATH

13. INSURED'S DATE OF MEMBERSHIP
    MM   DD   YY
    M     F

14. DATE OF CURRENT ILLNESS (First symptoms or injury)
    MM   DD   YY
    M     F

15. IF PATIENT HAS HAD NAME OR SIMILAR ILLNESS
    GIVE FIRST DATE
    MM   DD   YY
    M     F

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

19. RESERVED FOR LOCAL USE

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
    (For items 1, 2, 3, 4 to item 24E by line)

21. NATURE OF INJURY OR ILLNESS

22. A. DATE(S) OF SERVICE
    FROM
    MM   DD   YY
    TO
    MM   DD   YY

23. B. D. PROCEDURE(S) OR SERVICES OR SUPPLIES
    BILLING CODE(S) OR DESCRIPTION

24. E. DIAGNOSIS PONDER

25. F. CHARGES

26. G.渲染者提供者的ID号

27. TOTAL CHARGE
    $1

28. AMOUNT PAID
    $

29. BALANCE DUE
    $

30. SERVICE FACILITY LOCATION INFORMATION

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

32. BILLING PROVIDER INFO & PH #

NCCI Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CMB-09999 FORM CMS-1500 (08-05)
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.
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
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 Effective Date of Enrollment: 1/1/11

MCO

Name: Recipient Tom L

Last First MI

Address: 2109 Atlantic Street 2A

Street

Anywhere Maryland 21520

City State 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 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 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: ______________________  Effective Date of Enrollment: 01/12/11

MCO

Newborn Name: Recipient  Jill  I.

Last  First  MI

Newborn Address: 1207 Atlantic Avenue  26

Street  Apt.

Anywhere  Maryland  21200

City  State  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.
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 Name: ________________________

First Name: ________________________

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: ______________________

Rev: 6/1/11
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 Effective Date of Enrollment: 10/21/10

MCO
Name: Recipient Susan E.
Last First MI
Address: 1021 Atlantic Avenue 2E
Street Apt.
Anywhere Maryland 21502
City State Zip
Resident County: Allegany Medical Assistance Number: 01234567890
Birth Date: 11/07/05 Gender: M F X
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
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.
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: ____________________________ Date Received by IDEHA/CHSE: ____________________________

Confirmed Spans: ____________________________

Rev: 6/1/11
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 Effective Date of Enrollment: 7/25/10

MCO
Name: Recipient Tom L.
Last First MI
Address: 2701 Atlantic Avenue 2B
Street Apt.
Anywhere Maryland 21502
City State 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: ____________________________ Date Received by IDEHA/CHSE: __________
Confirmed Spans: ____________________________ Date Received by IDEHA/CHSE: __________

Rev: 6/1/11
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.
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

Received transfusion of blood/blood component (other than clotting factor)

First  Last
Month  Year  Month  Year

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):

Revised 6/1/11
# PATIENT HISTORY
(Information Required by the CDC when filing an HIV/AIDS Case Report)

<table>
<thead>
<tr>
<th>Name: Recipient</th>
<th>Jane</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last First MI</td>
<td></td>
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<table>
<thead>
<tr>
<th>Medical Assistance Number:</th>
<th>01234567890</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Submitted by MCO:</td>
<td>2/11/11</td>
</tr>
</tbody>
</table>

Please respond to all categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex with Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex with Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injected Non-Prescription Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received clotting factor for hemophilia/coagulation disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify disorder:</td>
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<td></td>
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<tr>
<td>Factor VII (Hemophilia A)</td>
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<tr>
<td>Factor IX (Hemophilia B)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify):</td>
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</tbody>
</table>

**Heterosexual** relations with any of the following:

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intravenous/injection drug user</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bisexual male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person with hemophilia/coagulation disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfusion recipient with documented HIV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transplant recipient with documented HIV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person with AIDS or documented HIV infection, risk not specified</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Received transfusion of blood/blood component (other than clotting factor)

<table>
<thead>
<tr>
<th>First Month Year</th>
<th>Last Month Year</th>
</tr>
</thead>
</table>

Received Transplant of tissue/organs or artificial insemination
(as a primary mode of transmission)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
</tr>
</thead>
</table>

Worked in a health-care or clinical laboratory setting (as a primary mode of transmission, documented COPHI)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
</tr>
</thead>
</table>

Revised 6/1/11
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
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: ____________________________________________

Rev. 5/1/11
MCO HEALTHCHOICE RECIPIENT ADDRESS CHANGE REPORT

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

<table>
<thead>
<tr>
<th>Date:</th>
<th>2/15/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name:</td>
<td>Recipient John T</td>
</tr>
<tr>
<td>Member Medical Assistance #:</td>
<td>01234567890</td>
</tr>
<tr>
<td>MCO Name:</td>
<td>MCO Advantage</td>
</tr>
<tr>
<td>MCO Representative:</td>
<td>Mary Representative</td>
</tr>
<tr>
<td>Phone:</td>
<td>410-123-4567</td>
</tr>
<tr>
<td>Change Reported By:</td>
<td>Jane Relative</td>
</tr>
<tr>
<td>Relationship:</td>
<td>Mother</td>
</tr>
<tr>
<td>Phone:</td>
<td>410-123-8903</td>
</tr>
<tr>
<td>Correct Address (Per Member):</td>
<td>1216 West East Street</td>
</tr>
<tr>
<td>Date Reported:</td>
<td>2/20/11</td>
</tr>
<tr>
<td></td>
<td>Apt. 6</td>
</tr>
<tr>
<td></td>
<td>Anywhere, MD 21200</td>
</tr>
<tr>
<td>Previous Address:</td>
<td>921 Second Street, Apt 2B</td>
</tr>
<tr>
<td></td>
<td>Anywhere, MD 21200</td>
</tr>
</tbody>
</table>

☐ 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: __________________________

Rev. 5/1/11
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
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:

________________________________________________________________________

Rev. 5/1/11
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 Jane M
Last
First
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

Date Reported: 2/20/11

Apt 6
Anywhere, MD 21202

Previous Address: 921 Second Street, Apt. 2B

Anywhere, MD 21212

☐ 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
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 Name: ____________________ First Name: _______ 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
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: 

Last First M.I.

Member Medical Assistance #: 01234567890

(Date: 2/15/11)

Part I

This information pertains to:
Name: [ ] SSN: [ ] DOB: [X] 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:

________________________________________________________________________
________________________________________________________________________

Rev. 5/1/11
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
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
# 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

<table>
<thead>
<tr>
<th>MCO Name: MCO Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO Representative: Mary Representative</td>
</tr>
<tr>
<td>Phone: 410-123-4529</td>
</tr>
<tr>
<td>Member Name: Recipient Jane L.</td>
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<tr>
<td>Last First M.I.</td>
</tr>
<tr>
<td>Member Medical Assistance #: 01234567890</td>
</tr>
</tbody>
</table>

(Requires box checked 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

DHMH USE ONLY

CM Agency:

Date Assigned:

☐ Incomplete

☐ Complete

Screener/Date

Date Received:

County

Date File Complete:

☐ Approved

☐ Denied

Decision Date:

Mail or Fax To:

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

Referral Source: __________________________
Address: _______________________________

Phone            Fax

PATIENT INFORMATION

Patient Name

Address

Apt. #

City

DOB:

State

Zip

Sex: M     F

SS #: ______________________

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

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<tr>
<th>Primary Diagnosis</th>
<th>Secondary Diagnosis</th>
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<td>ICD-9 Code</td>
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<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

### SUPPORTING INFORMATION (ATTACH COPIES)

- **History**
- **Physical**
- **Laboratory/Pathology**
- **Radiology**
- **Consultations**

**Comments**

**MD Signature** ____________________________  **Date** ________________
<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Disease</th>
<th>Age Group</th>
<th>Guidelines</th>
</tr>
</thead>
</table>
| 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.  
* Meets criteria for Acquired Immunodeficiency Syndrome (AIDS) diagnosis based on the 1987 AIDS surveillance case definition  
  or  
* Meets any of the criteria in (A) above |
| 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 immunofluorescence 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 | Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required. |
| 270.4     | Disturbances of sulphur-bearing amino-acid metabolism | 0-20 | Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required. |
| 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. |
## Rare and Expensive Disease List as of December 27, 2010

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Disease</th>
<th>Age Group</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>270.6</td>
<td>Disorders of urea cycle metabolism</td>
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<td>Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.</td>
</tr>
<tr>
<td>270.7</td>
<td>Other disturbances of straight-chain amino-acid metabolism</td>
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<tr>
<td></td>
<td>Glucoglycinuria</td>
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<td>Glycinemia (with methylmalonic acidemia)</td>
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<td>Hyperglycinemia</td>
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<td>Hyperlysinemia</td>
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<tr>
<td></td>
<td>Pипecolic acidemia</td>
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<td>Saccharopinuria</td>
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<tr>
<td></td>
<td>Other disturbances of metabolism of glycine, threonine, serine, glutamine, and lysine</td>
<td>0-20</td>
<td>Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.</td>
</tr>
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<td>270.8</td>
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<td>Sarcosinemia</td>
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<td>271.0</td>
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<td>Galactosemia</td>
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<td>Hereditary fructose intolerance</td>
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<td>Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.</td>
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<td>272.7</td>
<td>Lipidoses</td>
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<tr>
<td>277.00</td>
<td>Cystic fibrosis without ileus.</td>
<td>0-64</td>
<td>Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.</td>
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<tr>
<td>277.01</td>
<td>Cystic fibrosis with ileus.</td>
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<tr>
<td>277.02</td>
<td>Cystic fibrosis with pulmonary manifestations</td>
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<tr>
<td>277.03</td>
<td>Cystic fibrosis with gastrointestinal manifestations</td>
<td>0-64</td>
<td>Clinical history and physical exam; laboratory studies supporting diagnosis. Subspecialist consultation note may be required.</td>
</tr>
<tr>
<td>ICD-9 Code</td>
<td>Disease</td>
<td>Age Group</td>
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<tr>
<td>277.09</td>
<td>Cystic fibrosis with other manifestations</td>
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<td>Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.</td>
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<tr>
<td>277.2</td>
<td>Other disorders of purine and pyrimidine metabolism</td>
<td>0-64</td>
<td>Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required. Demonstration of deficient enzyme such as: alpha-L-iduronidase, iduronosulfate sulfatase, heparan sulfate sulfatase, N-acetyl-alpha-D-glucosaminidase, arylsulfatase B, beta-glucuronidase, beta-galactosidase, N-acetylhexosaminidase-6-SO4 sulfatase.</td>
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<td>277.5</td>
<td>Mucopolysaccharidosis</td>
<td>0-64</td>
<td>Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub specialist consultation note may be required. Demonstration of deficient enzyme such as: alpha-L-iduronidase, iduronosulfate sulfatase, heparan sulfate sulfatase, N-acetyl-alpha-D-glucosaminidase, arylsulfatase B, beta-glucuronidase, beta-galactosidase, N-acetylhexosaminidase-6-SO4 sulfatase.</td>
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<td>277.81</td>
<td>Primary Carnitine deficiency</td>
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<td>277.82</td>
<td>Carnitine deficiency due to inborn errors of metabolism</td>
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<td>284.01</td>
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<td>Other constitutional aplastic anemia</td>
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<td>286.4</td>
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<td>Cerebral lipidoses</td>
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<td>330.2</td>
<td>Cerebral degenerations in generalized lipidoses</td>
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<td>Cerebral degeneration of childhood in other diseases classified</td>
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<td>330.8</td>
<td>Other specified cerebral degeneration in childhood</td>
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<td>Clinical history and physical exam; laboratory studies supporting diagnosis. Sub specialist consultation note may be required.</td>
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<td>333.2</td>
<td>Myoclonus</td>
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<td>Clinical history and physical exam. Sub specialist consultation note may be required.</td>
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<tr>
<td>ICD-9 Code</td>
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<td>Age Group</td>
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<td>333.6</td>
<td>Idiopathic torsion dystonia</td>
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<td>Symptomatic torsion dystonia</td>
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<td>333.90</td>
<td>Unspecified extrapyramidal disease and abnormal movement disorder</td>
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<td>334.1</td>
<td>Hereditary spastic paraplegia</td>
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<td>Cerebellar ataxia NOS</td>
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<td>334.4</td>
<td>Cerebellar ataxia in other diseases</td>
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<td>334.8</td>
<td>Other spinocerebellar diseases NEC</td>
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<tr>
<td>334.9</td>
<td>Spinocerebellar disease NOS</td>
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<td>335.0</td>
<td>Werdnig-Hoffmann disease</td>
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<td>335.10</td>
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<td>335.11</td>
<td>Kugelberg-Welander disease</td>
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<td>335.19</td>
<td>Spinal muscular atrophy NEC</td>
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<td>Amyotrophic lateral sclerosis</td>
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<td>335.21</td>
<td>Progressive muscular atrophy</td>
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<td>335.22</td>
<td>Progressive bulbar palsy</td>
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<td>335.23</td>
<td>Pseudobulbar palsy</td>
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<td>335.24</td>
<td>Primary lateral sclerosis</td>
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<td>335.29</td>
<td>Motor neuron disease NEC</td>
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<tr>
<td>335.8</td>
<td>Anterior horn disease NEC</td>
<td>0-20</td>
<td>Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.</td>
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<td>335.9</td>
<td>Anterior horn disease NOS</td>
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<td>341.1</td>
<td>Schilder's disease</td>
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<td>343.0</td>
<td>Diplegic infantile cerebral palsy</td>
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<td>Clinical history and physical exam. Neurology consultation note may be required.</td>
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<td>343.2</td>
<td>Quadriplegic infantile cerebral palsy</td>
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<td>Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.</td>
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<tr>
<td>344.00</td>
<td>Quadriplegia, unspecified</td>
<td>0-64</td>
<td>Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.</td>
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<tr>
<td>344.01</td>
<td>Quadriplegia, C1-C4, complete</td>
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<td>Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.</td>
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<tr>
<td>344.02</td>
<td>Quadriplegia, C1-C4, incomplete</td>
<td>0-64</td>
<td>Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.</td>
</tr>
<tr>
<td>344.03</td>
<td>Quadriplegia, C5-C7, complete</td>
<td>0-64</td>
<td>Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.</td>
</tr>
</tbody>
</table>
### Rare and Expensive Disease List as of December 27, 2010

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Disease</th>
<th>Age Group</th>
<th>Guidelines</th>
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<tbody>
<tr>
<td>344.04</td>
<td>Quadruplegia, C5-C7, incomplete</td>
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<tr>
<td>344.09</td>
<td>Quadruplegia, Other</td>
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<td>359.0</td>
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<td>Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.</td>
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<td>359.1</td>
<td>Hereditary progressive muscular dystrophy</td>
<td>0-64</td>
<td>Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.</td>
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<td>359.21</td>
<td>Myotonic muscular dystrophy (Steinert’s only)</td>
<td>0-64</td>
<td>Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.</td>
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<tr>
<td>437.5</td>
<td>Moyamoya disease</td>
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<td>Clinical history and physical examination; supporting imaging studies and neurologic consultation note may be required.</td>
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<tr>
<td>579.3</td>
<td>Short gut syndrome</td>
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<td>Clinical history and imaging studies supporting diagnosis. Gastrointestinal sub-specialist consultation note may be required.</td>
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<tr>
<td>582.0</td>
<td>Chronic glomerulonephritis with lesion of proliferative glomerulonephritis</td>
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<td>Chronic glomerulonephritis with lesion of membranous glomerulonephritis</td>
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<td>582.2</td>
<td>Chronic glomerulonephritis with lesion of membranoproliferative glomerulonephritis</td>
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<td>582.4</td>
<td>Chronic glomerulonephritis with lesion of rapidly progressive glomerulonephritis</td>
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<td>582.81</td>
<td>Chronic glomerulonephritis in diseases classified elsewhere</td>
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<td>582.89</td>
<td>Other Chronic glomerulonephritis with lesion of exudative nephritis interstitial (diffuse) (focal) nephritis</td>
<td>0-20</td>
<td>Clinical history, laboratory evidence of renal disease. Nephrology sub-specialist consultation note may be required.</td>
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<td>582.9</td>
<td>With unspecified pathological lesion in kidney Glomerulonephritis: NOS specified as chronic hemorphagic specified as chronic Nephritis specified as chronic Nephropathy specified as chronic</td>
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<tr>
<td>585.1</td>
<td>Chronic kidney disease, Stage I (diagnosed by a pediatric nephrologists)</td>
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<tr>
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<td>Chronic kidney disease, Stage II (mild) (diagnosed by a pediatric nephrologists)</td>
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<tr>
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<td>Chronic kidney disease, Stage III (moderate) (diagnosed by a pediatric nephrologists)</td>
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<tr>
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<td>585.4</td>
<td>Chronic kidney disease, Stage IV (severe)</td>
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<td>585.6</td>
<td>End stage renal disease</td>
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<tr>
<td>741.00</td>
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<tr>
<td>741.01</td>
<td>Spina bifida with hydrocephalus cervical region</td>
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<tr>
<td>741.02</td>
<td>Spina bifida with hydrocephalus dorsal region</td>
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<td>741.03</td>
<td>Spina bifida with hydrocephalus lumbar region</td>
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<td>741.90</td>
<td>Spina bifida unspecified region</td>
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<td>Spina bifida cervical region</td>
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<td>741.92</td>
<td>Spina bifida dorsal region</td>
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<td>741.93</td>
<td>Spina bifida lumbar region</td>
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<td></td>
<td>Micrencephaly</td>
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<td></td>
</tr>
<tr>
<td>742.3</td>
<td>Congenital hydrocephalus</td>
<td>0-20</td>
<td></td>
</tr>
<tr>
<td>742.4</td>
<td>Other specified anomalies of brain</td>
<td>0-20</td>
<td></td>
</tr>
<tr>
<td>742.51</td>
<td>Other specified anomalies of the spinal cord</td>
<td>0-64</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diastematomyelia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>742.53</td>
<td>Other specified anomalies of the spinal cord</td>
<td>0-64</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hydromyelia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Rare and Expensive Disease List as of December 27, 2010

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Disease</th>
<th>Age Group</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>742.59</td>
<td>Other specified anomalies of spinal cord</td>
<td>0-64</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amyelia</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Congenital anomaly of spinal meninges</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Myelodysplasia</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypoplasia of spinal cord</td>
<td></td>
<td></td>
</tr>
<tr>
<td>748.1</td>
<td>Nose anomaly - cleft or absent nose ONLY</td>
<td>0-5</td>
<td>Clinical history and physical examination. Radiographic or other imaging studies and specialist consultation note (ENT, plastic surgery) may be required.</td>
</tr>
<tr>
<td>748.2</td>
<td>Web of larynx</td>
<td>0-20</td>
<td>Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
</tr>
<tr>
<td>748.3</td>
<td>Laryngotracheal anomaly NEC - Atresia or agenesis of larynx, bronchus, trachea, only</td>
<td>0-20</td>
<td>Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
</tr>
<tr>
<td>748.4</td>
<td>Congenital cystic lung</td>
<td>0-20</td>
<td>Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
</tr>
<tr>
<td>748.5</td>
<td>Agenesis, hypoplasia and dysplasia of lung</td>
<td>0-20</td>
<td>Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
</tr>
<tr>
<td>749.00</td>
<td>Cleft palate NOS</td>
<td>0-20</td>
<td>Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.</td>
</tr>
<tr>
<td>749.01</td>
<td>Unilateral cleft palate complete</td>
<td>0-20</td>
<td>Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.</td>
</tr>
<tr>
<td>749.02</td>
<td>Unilateral cleft palate incomplete</td>
<td>0-20</td>
<td>Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.</td>
</tr>
<tr>
<td>749.03</td>
<td>Bilateral cleft palate complete</td>
<td>0-20</td>
<td>Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.</td>
</tr>
<tr>
<td>749.04</td>
<td>Bilateral cleft palate incomplete</td>
<td>0-20</td>
<td>Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.</td>
</tr>
<tr>
<td>749.20</td>
<td>Cleft palate and cleft lip NOS</td>
<td>0-20</td>
<td>Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.</td>
</tr>
<tr>
<td>749.21</td>
<td>Unilateral cleft palate with cleft lip complete</td>
<td>0-20</td>
<td>Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.</td>
</tr>
<tr>
<td>749.22</td>
<td>Unilateral cleft palate with cleft lip incomplete</td>
<td>0-20</td>
<td>Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.</td>
</tr>
<tr>
<td>749.23</td>
<td>Bilateral cleft palate with cleft lip complete</td>
<td>0-20</td>
<td>Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.</td>
</tr>
<tr>
<td>749.24</td>
<td>Bilateral cleft palate with cleft lip incomplete</td>
<td>0-20</td>
<td>Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.</td>
</tr>
<tr>
<td>749.25</td>
<td>Cleft palate with cleft lip NEC</td>
<td>0-20</td>
<td>Clinical history and physical examination. Supporting consultation note from ENT/plastic surgery may be required.</td>
</tr>
<tr>
<td>750.3</td>
<td>Congenital tracheoesophageal fistula, esophageal atresia and stenosis</td>
<td>0-3</td>
<td>Clinical history and physical exam; imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
</tr>
<tr>
<td>751.2</td>
<td>Atresia large intestine</td>
<td>0-5</td>
<td>Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
</tr>
<tr>
<td>751.3</td>
<td>Hirschsprung's disease</td>
<td>0-15</td>
<td>Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
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<tr>
<td>751.61</td>
<td>Biliary atresia</td>
<td>0-20</td>
<td>Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
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<tr>
<td>751.62</td>
<td>Congenital cystic liver disease</td>
<td>0-20</td>
<td>Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
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<tr>
<td>751.7</td>
<td>Pancreas anomalies</td>
<td>0-5</td>
<td>Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
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<tr>
<td>751.8</td>
<td>Other specified anomalies of digestive system NOS</td>
<td>0-10</td>
<td>Clinical history and physical exam; laboratory or imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
</tr>
<tr>
<td>ICD-9 Code</td>
<td>Disease</td>
<td>Age Group</td>
<td>Guidelines</td>
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<tr>
<td>-----------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>753.0</td>
<td>Renal agenesis and dysgenesis, bilaterally only</td>
<td>0-20</td>
<td>Clinical history, physical examination, radiographic or other imaging studies. Sub-specialist consultation note may be required.</td>
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<tr>
<td>753.10</td>
<td>Cystic kidney disease, bilaterally only</td>
<td>0-20</td>
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</tr>
<tr>
<td>753.12</td>
<td>Polycystic kidney, unspecified type, bilaterally only</td>
<td>0-20</td>
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</tr>
<tr>
<td>753.13</td>
<td>Polycystic kidney, autosomal dominant, bilaterally only</td>
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</tr>
<tr>
<td>753.14</td>
<td>Polycystic kidney, autosomal recessive, bilaterally only</td>
<td>0-20</td>
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</tr>
<tr>
<td>753.15</td>
<td>Renal dysplasia, bilaterally only</td>
<td>0-20</td>
<td></td>
</tr>
<tr>
<td>753.16</td>
<td>Medullary cystic kidney, bilaterally only</td>
<td>0-20</td>
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<tr>
<td>753.17</td>
<td>Medullary sponge kidney, bilaterally only</td>
<td>0-20</td>
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</tr>
<tr>
<td>753.5</td>
<td>Exstrophy of urinary bladder</td>
<td>0-20</td>
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<tr>
<td>756.0</td>
<td>Musculoskeletal—skull and face bones</td>
<td>0-20</td>
<td>Clinical history, physical examination, radiographic or other imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
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<tr>
<td>756.4</td>
<td>Chondrodystrophy</td>
<td>0-1</td>
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<tr>
<td>756.50</td>
<td>Osteodystrophy NOS</td>
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<tr>
<td>756.51</td>
<td>Osteogenesis imperfecta</td>
<td>0-20</td>
<td>Clinical history, physical exam; imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
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<tr>
<td>756.52</td>
<td>Osteopetrosis</td>
<td>0-1</td>
<td>Clinical history, physical examination, imaging studies supporting diagnosis. Sub-specialist consultation note may be required.</td>
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<tr>
<td>756.53</td>
<td>Osteopoikilosis</td>
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<tr>
<td>756.54</td>
<td>Polyostotic fibrous dysplasia of bone</td>
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<tr>
<td>756.55</td>
<td>Chondroectodermal dysplasia</td>
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<td></td>
</tr>
<tr>
<td>756.56</td>
<td>Multiple epiphyseal dysplasia</td>
<td>0-1</td>
<td></td>
</tr>
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### Rare and Expensive Disease List as of December 27, 2010

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