Maryland Medicaid Provider Manual

Created 1/31/2025

Table of Contents

About Maryland Medicaid 3
Telligen, Inc. 4
Web-Based PA Electronic Review System 6
Accessibility & Contact Information 6
A. Submitting Requests 7
B. When you Need Information or Assistance 7
C. Questions about the UCA 8
D. Questions about Submitting Review Requests or about Using Qualitrac 8
E. Checking the Status of a Request or Submitting an Inquiry about a Request 8
F. Telligen Customer Service 8
Utilization Management 10
Overview of Services 11
Telligen Review Process 13
Review Determinations 14
Review Criteria 16
Timings of Reviews 16
Review Submission Requirements 17
Acute Care Medical – Surgical Services 17
DMEPOS Reviews 23
Parenteral and Enteral Nutrition (PEN) Items and Services 35
Audiology Reviews 38
Air Ambulance 41
Long-Term Services and Supports (LTSS) Reviews 43
Home and Community-Based Services (HCBS) 49

About Maryland Medicaid

Medicaid is a public health insurance program that provides free or low-cost health insurance for eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. It is the largest healthcare program in the United States. In Maryland, Medicaid covers about 1.8 million people. Nearly one in four Marylanders get their health insurance through Medicaid, and half of those covered are children. Locally, people also call it Medical Assistance.
For additional information about Maryland Medicaid, visit their website at: https://health.maryland.gov/Pages/Home.aspx.

Medicaid funds the cost of health care services for approximately 1.4 million Marylanders who access services in a combination of settings that include acute hospitals and long-term services and supports. Over 42,000 individuals utilize Maryland Medicaid's long-term services and supports which are provided via home and community-based settings—through state plan programs as well as special Medicaid programs known as waivers—as well as in institutional settings

Utilization Management Program

Medicaid is a federal and state program created to provide medical assistance to eligible, low-income populations. This service provides access to quality health care coverage for vulnerable Marylanders. Maryland Medicaid health benefits are available for populations including children, low-income families, the elderly, the blind, or the disabled, and pregnant women. Individuals must meet certain requirements to receive benefits and services.
Eligible members do not directly receive money from Medicaid for health benefits. Enrolled and qualified Medicaid providers are reimbursed for health services.

Utilization Control Agent (UCA)

Beginning in February 2016, Telligen Inc. began performing utilization reviews. Telligen was awarded the new UCA contract in 2023 by to the Maryland Department of Health (MDH) to serve as its UCA, to review Fee-For-Service (FFS) services provided to Medicaid beneficiaries in the State of Maryland. Under this contract, Telligen ensures that all Medicaid services meet medical guidelines for medical necessity, appropriateness, and length of service.

For additional information on service authorization processes and provider education opportunities, please visit **Telligen's provider portal** at: **https://telligenmd.qualitrac.com**

UCA Requirements

Telligen has developed written standard operating procedures, approved by MDH, for Utilization Control (UCA) services. These procedures comply with Federal and State laws and regulations, the Maryland COMARs, transmittals, and policies promulgated by MDH when conducting reviews.

Fee schedules are provided on MDH's public website. All MDH transmittals are also available on their website. Refer to MDH's Comprehensive Fee Schedule and individual fee schedules to identify procedure codes with prior authorization requirements.

Telligen, Inc.

Telligen, an employee-owned company, is the federally designated QIO for Iowa, Illinois, Colorado, and Oklahoma. We perform Utilization Management (UM), Case Management (CM), and Population Health Management (formerly Disease Management) activities tailored for FFS Medicaid beneficiaries, including members in the private sector (e.g., Group Health Insurance companies, Self-Insured Employer Groups, Managed Care Plans, etc.). Telligen's long-established national Utilization Management (UM) program began as a Medicare Peer Review Organization (PRO) focusing on case review in Iowa (1984 to 2014) and in Illinois (1996 to 2014) – each of which involved ***medical necessity*** and ***quality of care reviews*** for the *Medicare Beneficiary Protection Program*. Similar to today's UM work, our **first**- and second-level clinical reviewers evaluate utilization management requests to ensure that clinical documentation supports medical necessity decisions.

As a Medicaid UM and a Medicare QIO contractor for more than 50 years, Telligen's goal is to continue improving the quality of care delivered to our customers and, through our review process, ensure appropriate utilization of medically necessary services and resources.

Our Mission

Our mission is to transform lives and economies by improving health.

Our Vision

The vision of Telligen is to be one of the most sought-after companies to transform the health of populations.

Our Core Values

- Ownership
- Integrity
- Ingenuity
- Community.

Office Locations

Telligen is headquartered in West Des Moines, Iowa, with offices in Mississippi, Maryland, Massachusetts, Oklahoma, Colorado, Idaho, Minnesota, and Virginia. It offers diverse products and services and works with millions of people nationwide.

Program Goals

Telligen aims to continue our collaborative partnership with MDH and Maryland Medicaid providers to continue our UM/QIO coordinated, integrated, and comprehensive approach to delivering care and services to meet or exceed Medicaid beneficiaries' expectations.

Program Objectives:

- Evaluate service requests by determining their medical necessity, efficiency, appropriateness, and consistency with the participant's diagnosis and required level of care.
- Foster safe practices through peer review, concurrent review, risk management, and medical record review to optimize resource utilization, promote appropriate care, and improve member safety and appropriateness of care.
- Support the delivery of the highest quality and continuity of care through ongoing activities performed by UM clinical staff.
- Achieve high satisfaction among members and providers by reducing provider burdens by improving patient access and accessibility to and timeliness of care and services.
- Monitor delivery and access to care and the quality and appropriateness of services rendered to FFS participants.
- Improve provider education and communication through feedback via quality and improvement committees, newsletters, surveys, provider portals, and ongoing provider training.
- Promote health care delivery in accordance with MDH, Utilization Review and Accreditation Committee (URAC), and National Committee for Quality

Assurance (NCQA) accreditation standards, evidence-based practice guidelines, industry standards, and Telligen policies and procedures.

Web-Based PA Electronic Review System

Telligen's Web-Based system ***Qualitrac*** is our proprietary, MITA-aligned, mobile-friendly Population Health Management application for MDH's UCA UM program. Reporting, a Software as a Service (SaaS) solution consisting of four defined modules: **UM**, **CM**, ***Care Management***, and ***Quality Measurement*** and ***Reporting***, is available 24 hours, 365 days per year. The electronic review request system offers providers an easy way to enter, update, and track patient authorization requests. Once an authorization request is submitted and/or updated, providers immediately receive an email notification that the system has updated the status of their request, ensuring timely and transparent access to the review process. Outcomes and all correspondence are easily accessible in the portal in real-time to ensure authorized provider users can access information needed to provide the best quality care for Medicaid beneficiaries.

Maryland Medicaid Providers have 24/7 access to ***Qualitrac***, and training is provided periodically via Telligen webinars**.** Telligen's dedicated Maryland Provider Portal also includes education and training materials to assist providers with understanding the different functions of ***Qualitrac***. A provider portal user guide is also available on our website: https://telligenmd.qualitrac.com. This guide provides step-by-step instructions for use in completing responsibilities within the **Qualitrac** health management system.

All authorized users can access our web-based (Qualitrac) electronic review system via a secured login. As authorized users, providers can view and securely download all data, analytics, or reports specific to each provider (e.g., Office Manager) as defined by the user's profile and security access.

Accessibility & Contact Information

This section provides information about accessing the UCA and important contact information. At the end of the section, we provide a quick reference guide of website links and toll-free telephone and facsimile (fax) numbers.

A. Submitting Requests

our **Methods of Submission**

All review requests should be submitted to Telligen through our proprietary, HIPAA-compliant web-based electronic review system, ***Qualitrac***. This system is accessible via Maryland Provider Portal, https://telligenmd.qualitrac.com, seven (7) days a week—see Figure 1 below.



Figure 1 – Telligen Website – Provider Portal

All requests must be submitted via the portal.

B. When you Need Information or Assistance

MDH and Telligen are committed to delivering exceptional services to our customers. We offer a variety of ways for Providers to efficiently obtain the information or assistance you need. In the following sections, we identify useful resources by topic or type of assistance needed.

C. Questions about the UCA

Providers who have questions or want to learn more about the MDH UCA UM program, please refer to the following resources:

A. Resources available on our website: : https://telligenmd.qualitrac.com
   a. Frequently Asked Questions (FAQ's): Available under the FAQ's tab.
   b. Education & Training Materials: Copies of training and education presentations are available under "*Education & Training*" tab.
   c. This Provider Manual: Telligen Provider Manual is available under the "Document Library" tab.

B. Telligen customer service staff: Our Toll-free number is **1-888-276-7075.**.

C. MDH website: https://health.maryland.gov/mmcp/Pages/UCATransition.asp

D. Questions about Submitting Review Requests or about Using Qualitrac

Providers can use one of the following resources:

1. ***Qualitrac Provider Portal User Guide*** for how to submit a review request is available on our website: https://telligenmd.qualitrac.com
2. Telligen's Website: https://telligenmd.qualitrac.com for helpful resources.

E. Checking the Status of a Request or Submitting an Inquiry about a Request

Providers can choose one of the following options:

1. Check the status of a previously submitted request: Use your secure ***Qualitrac*** login and check the information on the "**Cases**" tab.
2. Contact Customer Service during normal business hours.

Qualitrac is available 24 hours a day, seven (7) days a week. Using ***Qualitrac*** is the most efficient way to obtain information about requests. You may also contact our customer service staff; please see "**Telligen Customer Service**" below for additional information.

F. Telligen Customer Service

Website: https://telligenmd.qualitrac.com

The Telligen website is a central location to access information including prior authorization forms, admission criteria, and informational material

Toll Free Contact Center: 888-276-7075

Hours of Operation: **Monday** through **Friday**, 8:00 a.m. to 5:00 p.m. Eastern Standard Time (EST), excluding state holidays.

If you call our customer service unit outside business hours, you can leave a message. Calls received after business hours are answered by customer staff the following business day.

Utilization Management

The purpose of this document is to notify providers of the process that Telligen will follow for review of services provided to Maryland Medicaid members. The Maryland Department of Health contracts with Telligen to:

- Review the medical necessity of an admission, continued stay and/or course of treatment or service.
- Assess for the quality of care of those services so that they meet the professionally recognized standard of care
- Assess the setting the care was delivered in was appropriate for the type of service provided by the standards of practice
- Determine if the level of care was appropriate for the services rendered.
- Provide a monitoring system to determine that medical services are delivered at the appropriate level of care in a timely, effective, and cost-effective manner, to examine and improve the quality of medical care, and to evaluate practice patterns of healthcare delivery.

Federal regulations require Medicaid programs to review any service (admission or procedure) where it is anticipated or known that the service could either be over or underutilized, or otherwise abused, by providers or members, or easily result in excessive, uncontrolled Medicaid costs. This is accomplished through authorizations for inpatient admissions, durable medical equipment, disposable medical supplies, home and community-based waiver services and long term support and services.

Providers are required to complete the prior authorization process in instances where the member has other insurance with another carrier or Medicare. If prior authorization is not obtained and the primary carrier does not reimburse for the services, Medicaid may deny the claim due to lack of prior authorization.

Overview of Services

A. Scope of Services

Telligen, Inc in accordance with a contract agreement with the ***Maryland Department of Health*** is responsible for the performance of UM reviews of services for the FFS population. Under this contract agreement, Telligen is responsible for providing UM for the following services:

1. Acute Care Medical-Surgical Services
2. Durable Medical Equipment (DME)/Disposable Medical Supplies (DMS)
3. Audiology Services
4. Air Ambulance
5. Long Term Care Services and Support
6. Home and Community-Based Services

B. Program Components – Acute Care Medical – Surgical Services

The UM program includes the following medical-surgical service reviews provided by Telligen:

1. Pre-Admission Review of Elective Admissions
2. Concurrent and Continued Stay Reviews (CSR)
3. Retrospective Reviews
4. Undocumented/Unqualified Alien Emergency Admission Reviews
5. Reconsideration Reviews
6. Administrative Day Reviews
7. Ancillary Services Reviews

C. Program Components – DME/DMS

The UM program includes the following DME/DMS prior authorization reviews provided by Telligen:

1. Durable Medical Equipment (DMEPOS)
2. Disposable Medical Supplies (DMS)
3. Parenteral and Enteral Nutrition services (PEN)
4. Power Wheelchairs for residents in nursing facilities

D. Program Components – Audiology

The UM program includes the following Audiology prior authorization reviews provided by Telligen:

1. Hearing Aides
2. Cochlear Implants
3. BCROS/CROS

E. Program Components – Air Ambulance

The UM program includes the following transport reviews provided by Telligen:

1. Rotary Wing Transports – Retrospective reviews

F. Program Components – Long-Term Services and Supports (LTSS)

The UM program includes the following Long-Term care service reviews provided by Telligen:

1. Nursing Facility Level of Care Medical Eligibility Reviews
2. Nursing Facility Level of Care Continued Stay Reviews
3. Special Pediatric Medical Eligibility and Continued Stay Reviews
4. Adult Chronic Medical Eligibility and Continued Stay Reviews
5. Level I PASRR Reviews
6. Hospice Reviews for beneficiaries on their 6th or more benefit period
7. MDS Audits
8. Ventilator Care Validation Audits

G. Program Components – Home and Community-Based Services (HCBS)

The UM program includes the following HCBS reviews provided by Telligen:

1. Medical Adult Day Care (MADC)
2. Brain Injury (BI)
3. Community Options (CO)
4. Community First Choice (CFC)
5. Community Personal Assistance Services (CPAS)
6. Model Waiver (MW)
7. Program of All-Inclusive Care for the Elderly (PACE)
8. Plans of Service Reviews

Telligen Review Process

Auto-Authorization

When a request is initially entered in **Qualitrac, the system applies a series of business rules or clinical algorithms to ensure the review meets medical necessity criteria for certain diagnoses** and clinical conditions. This process is integrated with MCG clinical decision support guidelines, allowing the provider to enter and upload applicable clinical information, resulting in an immediate **approval** or **referral** to a nurse reviewer if the submitted request is complete (e.g., Provider submits all required supporting information).

There are two outcomes of the auto-authorization process (for which providers receive immediate notification of decisions):

1. Approval of the service via the clinical algorithm.
2. Failure to meet auto-authorization results in an automatic referral to a nurse for a manual review.

Telligen first level reviewers (nurse reviewer) will manually review each request and prepayment review request received that is not certified by auto-authorization, along with any required supporting documentation to support the need for services.

First-Level Medical Necessity Review

Upon receiving a request, Telligen will confirm Provider and Medicaid member eligibility through **Qualitrac** and MDH's Medicaid Management Information System (MMIS). Once eligibility is confirmed, our nurse reviewers will review the clinical information against approved clinical criteria (e.g., MCG or state-specific criteria) to determine the medical necessity of the services under review.

When the applicable policies are satisfied, the nurse approves the services as proposed, and approval outcomes are entered into Qualitrac.

Electronic notifications are generated for adverse determinations to providers through **Qualitrac.** When a review determination is rendered, Qualitrac immediately generates an email notification to the provider who requested the review.

Referral to a Peer Reviewer

Telligen first-level reviewers may not render an adverse determination. They refer any request they cannot approve to a peer reviewer.

Second Level (Peer Review) **Review Process**

When we schedule a peer review, every effort is made to match the case being reviewed to a physician of the same specialty or a physician experienced in quality utilization management. During the review process, the peer reviewer uses his/her clinical experience and judgment.

Review Determinations

In accordance with 42 C.F.R. Subpart E, Telligen's process includes a mechanism to ensure all ordering and referring physicians or other professionals providing services under the State plan are enrolled as participating Medicaid providers before authorizing review requests.

Telligen nurses, physicians, and other licensed health professionals conducting reviews of medical services and other clinical reviewers conducting specialized reviews in their area of specialty are licensed or certified by the Maryland state licensing agency or hold a multi-state license with Maryland privilege.

Approvals

Telligen's process includes the issuance of medical necessity approvals. For approved requests, Qualitrac will generate an approval with an authorization number if the requested service meets all policy and medical criteria necessary for authorization. Letters are not generated for approvals.

Requests for Information

Telligen reviews all requests to ensure supporting information is received, which allows review staff to determine if services meet medical necessity requirements. Requests are placed in a "pause" status (e.g., "Pending Additional Information") if the provider submits a request for authorization with **incomplete**, **inadequate**, or **ambiguous** information. When a request cannot be completed with submitted information, Telligen *reviewers will issue a Request for Information through the Qualitrac portal.*

Technical Denials

Requests are technically denied when additional information is not received in the allowed timeframe of the review's "pause" status (pending status) and Telligen is unable to complete the review.

Telligen will issue a technical denial for services when the case does not meet Federal and State laws and regulations, MDH policies and/or formal memorandums or is technically insufficient.

Denials

In accordance with MDH contract requirements, Telligen complies with 42 C.F.R. § 438.210 (b)(3), which requires that any decision to deny a service request or to authorize service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the Member's medical, behavioral health, and/or long-term services and supports needs.

All denials, modifications, or reductions in services by the second-level reviewer are made by a physician reviewer licensed in the State of Maryland.

Reconsiderations

Following MDH requirements, Telligen conducts reconsiderations and makes determinations upholding, modifying, or reversing the review outcome by taking into consideration all pertinent information, including any additional or new information that may be presented during the reconsideration.

Telligen will provide, at a minimum, a reconsideration process for reviews in which the decision is a:

1. Denial, modification, or reduction of services/items based on medical necessity.
2. Denial based on Federal and State laws and regulations, MDH policies, and/or formal memoranda that exclude coverage.
3. Other adverse decisions as defined by the Department.

Providers may submit a reconsideration request via Qualtrics. Telligen issues all review determinations in accordance with MDH requirements and within review timeframes.

Review Criteria

Medical Necessity

All medical necessity UM decisions are made using objective and evidence-based guidelines, which allows Telligen to standardize decisions, promote evidence-based practices, and support the member's well-being. The guidelines used to make medical necessity determinations include:

- MCG (formerly Milliman Clinical Care Guidelines)
- Maryland COMAR
- Maryland Department of Health Specific Criteria via transmittals
- CMS Local Coverage Determination Guidelines
- Maryland Medicaid Billing Manual
- CMS 1500 Provider Manual

The stay/procedure/service will be approved if:

- Covered under Maryland Medicaid Fee For Service
- Medically necessary and any medical necessary criteria/guidelines are met.

Determination of medical necessity is based on criteria established by the Maryland Department of Health COMARs. and a review of all submitted documentation.

Please be aware that Telligen's determination does not guarantee Medicaid payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms, conditions, and limitations of the Medicaid program.

Timings of Reviews

In this section we summarize the various types of review.

1. **Prospective Review** - Includes the review of medical necessity for the performance of services or scheduled procedures before the service is

rendered or before admission. Also referred to as prior authorization or precertification.

2. **Concurrent Review** - Includes a review of medical necessity decisions made while the patient is currently in an acute or post-acute setting or when an episode of care needs to continue beyond the initial authorization period.
3. **Continued Stay Review –** These are reviews built off of a Concurrent or Prospective review. These reviews are a continuation of the same admission and continue at regular specified intervals until discharge.
4. **Retrospective Review** - Reserved for medical emergent conditions or situations where the provider has insufficient information required to submit a prospective or concurrent review or the recipient obtains retrospective eligibility. Retrospective reviews shall include review of service documentation to confirm medical emergent condition or situation along with medical necessity.
5. **Prepayment Review** - Includes review of documentation of the services rendered that is conducted prior to the provider receiving reimbursement. All reviews for the UCA contract are prepayment reviews.
6. **Level of Care Review** - A determination made by factoring in an individual's physical, functional, mental, social, and/or emotional capacity to meet his or her own needs and is not solely based on diagnosis.

Review Submission Requirements

This section covers the different review types that are reviewed by the UCA and the submission requirements for each.

Acute Care Medical – Surgical Services

Acute care medical-surgical reviews include the following review types: Pre-Admission Review of Elective Admissions, Concurrent and Continued Stay Reviews, Retrospective Reviews, Undocumented/Unqualified Alien Emergency Admission Reviews, Reconsideration Reviews, Administrative Day Reviews, and Ancillary Services Reviews

Pre-Admission Review of Elective Admissions

Prior Authorization reviews are performed for elective admissions for Maryland Medicaid Fee-for-Service recipients. The prior authorization is for the facility in

which the procedure is being performed, NOT for the provider performing the procedure. The request can be submitted up to 30 days prior to the hospital admission. The request must include the following documentation:

- Reason for the admission
- Progress notes from the rendering provider
- Surgical procedure/summary
- Relevant clinical history/indication for the procedure
- Laboratory and imaging results

All documentation must be from within the last 6 months prior to the submission.

The timing for this review type must be ***prospective.***

Receipt of a prior authorization for an admission does not guarantee payment.

If the admission date needs to be changed, please submit a correction form with the correct date. The correction form can be found in the documents library at: https://telligenmd.qualitrac.com.

Concurrent and Continued Stay Reviews (CSR)

Initial concurrent reviews per federal mandate and COMAR needs to be requested by providers for Fee for Service (FFS) recipients for inpatient hospital stays.

The acute hospital provider submits the initial concurrent review in Qualitrac (QT) within 48 hours of admission. *If the recipient does not have Medicaid (MA) eligibility upon admission, the hospital is required to begin concurrent reviews within 48 hours of MA eligibility determination.*

The acute hospital provider then submits subsequent CSR requests in QT per submission protocol of Monday-Wednesday-Friday.

The review timing for the initial case is *Concurren*t and each review after the initial should have a timing of *Continued Stay*.

The admission type can be *elective, urgent or emergent*.

Concurrent and CSRs are not required for X02/X03 eligibility, Medicare as the primary payer or a member in an MCO.

The following information and documentation should be submitted:

- Current medical status.
- Treatment received to date.
- A proposed treatment plan for the continued stay.
- Additional information such as dated notes, surgical/procedure summary, laboratory results, imaging results, or other records based on the provider's clinical judgment for each case

All documentation should contain 2 patient identifiers. Approval of a concurrent or CSR review does not guarantee payment. Concurrent and CSRs cannot be submitted to the Maryland Department of Health for payment.

Retrospective Reviews

A retrospective review is the process of reviewing a medical record from a hospital to ensure that the services rendered meets the definition of medical necessity for an acute inpatient stay for Medicaid Fee-for-Service recipients. This review is known as a 3808 retro review. Retrospective reviews must be submitted within 12 months of the discharge or eligibility date.

Required documentation for a 3808 review includes the following:

- Emergency Room (ER) note (if applicable), the
- Discharge Summary,
- The physician's admission order and daily progress notes
- Physician consultations, if applicable
- Surgical notes, if applicable
- Nursing notes
- Social work notes
- Labs/other studies
- Medication Profile
- EOB from primary insurance if applicable
- 1288, if requesting administrative and/or ancillary services

Each day of a hospitalization is reviewed for medical necessity using MCG criteria.

Requests for inpatient psychiatric treatment are not reviewed by Telligen.

Reminder: Medicaid is always the payer of last resort. All other pay sources must be billed and paid/denied prior to submitting a 3808 review or billing Medicaid.

Undocumented/Unqualified Alien Emergency Admission Reviews

The purpose of the review is to determine if the visit met medical necessity, based upon COMAR 10.09.24.05-2. The X02/X03 is the initial process that occurs when these potential recipients receive care and are in the process of being granted a special temporary period of Medical Assistance.

Emergency Services - Emergency medical services, including labor and delivery services, are for the treatment of an emergency medical condition that, after sudden onset, manifests itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention can reasonably be expected to result in: 1) placing the individual's health in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part. Emergency medical services extend from when the individual enters a hospital to receive the emergency medical services until the individual's emergency condition or other medical condition requiring the emergency medical services is stabilized as determined by the Department.

One of the following numbers must be on the OES 401 form and matches the member ID used to submit the request.

- MA ID (11-digits)
- IRN (9-digits)
- MPI (10-digits)

Required documentation includes:

- A complete, signed and dated OES 401 form
- Emergency room notes
- History and physical
- Discharge summary

Other Covered Conditions

1. Labor is an emergency condition. Hospital has to observe to see that contractions stop and that delivery isn't imminent.
2. ESRD with dialysis is always considered emergent

Conditions Not Covered

1. Direct elective admits are usually not approved as emergency services. Scheduled elective admissions such as colostomy take down, chemotherapy

or radiation therapy are not emergency services that can be paid for by Medicaid.

2. Any care rendered in a setting other than an ED – Rehab hospitals, chronic hospitals, nursing facilities, outpatient departments, local health departments, FQHCs, physician, dental and podiatry offices, freestanding radiology centers, outpatient pharmacies, etc. do not qualify as providers for these emergency medical services. In addition, routine prenatal care or postpartum care and organ transplants or services related to organ transplants are not considered emergency services as per the regulations

Reconsideration Reviews

A reconsideration is a first level request from a provider on the initial determination of the Retrospective Review. The provider may submit a reconsideration if they feel that the initial decision should be re-reviewed, typically accompanied by additional information for consideration by an alternate reviewer from the initial decision. The reconsideration is completed prior to a request for an Administrative Review by the Department and a formal appeal to the Office of Administrative Hearings.

Reconsideration requests must be submitted within **30 days** of the initial retrospective review determination.

Documentation for a reconsideration request should include:

- A copy of the initial retrospective review determination letter
- An appeal letter which includes the dates being appealed.
- Any additional documentation, if applicable

Administrative Day and Ancillary Services Reviews

As part of the retrospective review process – Telligen will review provider requests for administrative days and medically necessary ancillary charges on days otherwise denied at the acute level of care. Administrative days are requested when the provider has sought to place the participant at a lower level of care other than acute inpatient - while the facility awaits placement and transfer of the participant. **Administrative days and the medically necessary ancillaries MUST be requested at the time of the retrospective review request**. The 1288 form will be utilized to specify

the dates, requested ancillaries for review, and verification of contacted placement attempts.

The 1288 form is primarily used for situations where a lower level of care, which may often be a nursing facility level of care, is requested and/or if the patient is still inpatient awaiting transfer for another issue in the absence of acute inpatient care. The purpose of the administrative day request is to have a method by which the hospital will receive reimbursement in cases where they are providing medically necessary ancillary services for a participant who no longer needs acute level of care hospitalization. The provider may only request a select set of medically necessary ancillaries to be reviewed in conjunction with an administrative day. The list of ancillaries for determination of medical necessity is:

Ancillary services performed on a Denied Acute Day	CPT Code	Revenue Code
Labs		
Basic Metabolic Panel (BMP)	80048	0305
Comprehensive Metabolic Panel (CMP)	80053	0305
Complete Blood Count (CBC) with or without White Blood Cell (WBC) Differential.	85025	0305
Prothrombin Time (PT) with INR	85610	0305
Mg	83735	0301
Phos	84100	0301
Calcium	82310	0301
Med/Surg Supplies		0300
Radiology		
Chest X Ray (2 view)	71046	0324
Abdominal X Ray	74018	0320
CT Scan General Classification		0350
CT Scan Abdomen w/ contrast	74150	0352

CT Scan Abdomen w/o contrast	74160	0352
CT Scan Head w/contrast	70460	0351
CT Chest/Thorax w/contrast	71260	0352
Cardio		
EKG (tracing only)/ECG		0730, 0732
Renal		
Dialysis		0801, 0802
Respiratory		
Respiratory Services- General Classification		0410

The 1288 and instructions for completion can be found in the Documents Library at https://telligenmd.qualitrac.com.

DMEPOS Reviews

This section covers requirements for DME, DMS, PEN and power wheelchairs for SNF prior authorizations.

Telligen completes reviews for Maryland Medicaid participants who request Durable Medical Equipment (DME), Disposable Medical Supplies (DMS), NF Power Wheelchairs, and Audiology Services requiring authorization. This review is conducted to determine eligibility, medical necessity, utilization and/or continuation of medical need for the items provided to Maryland Medicaid participants to support their independence in their home, school, place of employment, community settings, and long-term care settings, when appropriate. The reviewer makes determinations for rental vs. purchase, denial, or requests for additional documentation based on the findings in the review. The intention is to ensure that the most cost-effective and medically necessary equipment is provided for the participants.

The minimum documentation required for all DME/DMS requests includes:

- A signed and dated physician's order for the equipment/supplies
- A signed and dated face-to-face
- An evaluation or letter of medical necessity for the requested item
- Cost information if the item is for individual consideration

See the sections below for specifics for some equipment.

High Frequency Chest Wall Oscillation Devices (HFCWO) E0483

Requests for HFCWO systems are medically necessary for the following conditions and must be supported with documentation of a diagnosis and treatment plan. Treatment failure with regular chest physical therapy, suctioning, nebulization, medication, spacers and positive expiratory pressure devices must be documented along with other measures attempted to address contributing conditions.

A recipient must have one of the following conditions to be considered for a HFCWO:

Bronchiectasis that has been confirmed by a standard CT scan and which is characterized by:

- A daily productive cough for at least six continuous months, or
- Frequent exacerbations requiring antibiotic therapy (i.e., more than four times a year);
- Cystic Fibrosis; or

One of the following neuromuscular disease diagnoses:

- Post-polio
- Acid maltase deficiency
- Anterior horn cell diseases
- Multiple sclerosis
- Quadriplegia
- Hereditary muscular dystrophy
- Myotonic disorders
- Other myopathies
- Paralysis of the diaphragm

If the recipient presents with chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis , the item is not considered medically necessary. If the recipient does not present with any of the above conditions, the claim will be denied as not reasonable and not medically necessary. It is not reasonable and necessary for a recipient to use both an HFCWO device and a mechanical inexsufflation device (e.g., Coughalator, Cough Assist). A recipient may qualify for an inexsufflation device if he/she has ineffective cough and no private duty nursing. If the recipient is over 21 years of age a request for HFCWO will be denied if the recipient does not have a qualifying diagnosis.

Apnea Monitors

The following documentation must be submitted for each authorization of an apnea monitor:

- Diagnosis and statement of medical appropriateness from the practitioner, and;
- Copies of hospital records documenting medical appropriateness, and/or;
- Copies of sleep studies or memory monitor reports, and/or;
- Documentation of ALTE from log, nursing notes or doctor's progress records.

Peristeen Irrigation System

Documentation must include all of the following:

- An order for the Peristeen unit which is signed by the prescribing practitioner;
- Justification which supports the medical appropriateness of the unit, which includes a face-to-face evaluation that references the neurogenic bowel;
- Verification from the prescribing provider that other conservative bowel management alternatives have been tried and been proven ineffective (initial management involving diet, bowel habit, laxatives or constipating medications have failed); and

Participant must be at least 2 years of age.

Specialized Car Seats

A specialized care seat evaluation must address issues including:

- Airway integrity
- Skin integrity
- Allowance of voluntary movement where it does not negatively impact safety
- Proper positioning
- Type of release mechanism to ensure the safety of beneficiaries with behavioral and/or judgement issues
- The ability of the device to support the participant properly despite seizure activity or muscle spasms
- The ability of the device to support a growing child over time including growth in weight and height
- Parent/caregiver ability to consistently and properly use the device for its intended purpose and according to manufacturer specifications.

Speech generating devices

A formal written SLP evaluation must include:

- Current communication impairment, including the type, severity, language skills, cognitive ability, and anticipation course for the impairment
- An assessment of whether the individual's daily communication needs could be met using other natural modes of communication
- A description of the function of a specific device and any accessories;
- Rationale for selection of a specific device and any accessories;
- Demonstration that the participant possesses a treatment plan that includes a training schedule for the selected device;
- The cognitive and physical abilities to effectively use the selected device and any accessories to communicate;

Spare and Backup Equipment

The Maryland Medical Assistance Program does not cover spare or back-up equipment. Claims for backup equipment will be denied as not reasonable and necessary – same/similar equipment.

Backup equipment must be distinguished from multiple medically necessary items which are defined as, identical or similar devices each of which meets a different medical need for the beneficiary. Although Medicare does not pay separately for backup equipment, Medicare will make a separate payment for a second piece of equipment if it is required to serve a different medical purpose that is determined by the beneficiary's medical needs.

Disposable Medical Supply (DMS) Criteria

DMS consumable or disposable items with minimal or no potential for reuse which are used to serve a medically necessary purpose and, with the exception of disposable gloves and incontinence supplies, have no practical use in the absence of illness, injury, disability, or health condition.

A licensed occupational or physical therapist or physiatrist cannot be employed by, under contract with, or receiving financial remuneration from any enrolled DMS provider from which he/she is prescribing supplies for the participant.

All DMS must be:

- Medically necessary;
- Functionally appropriate for the individual participant;
- Adequate for the intended medical purpose;
- For conventional use; and
- For the exclusive use of the participant.

Medical supplies must be needed for use with one of the following:

- Colostomy, urostomy, ileostomy appliances;
- Surgical, wound, and burn dressings;
- Gastric feeding sets and supplies;
- Urinary catheters, irrigation apparatus and related items;
- Tracheostomy and endotracheal care supplies;
- Disposable items, which if not provided could reasonably cause the participant to require emergency treatment, become hospitalized, or be placed in a long-term care facility; or
- In support of the Medicaid covered DME equipment used by the participant.

Medically necessary DMS are covered in the participant's:

- Home
- School
- Place of employment

Custom Cranial Remolding Orthosis

A custom cranial remolding orthosis is a non-invasive device used to correct the symmetry of an infant's skull.

Custom cranial remolding orthotic devices are covered when it is determined medically necessary to correct a moderate to severe craniofacial deformity. Supporting documentation, at a minimum, must include:

- Prescription from an orthopedic or craniofacial surgeon;
- Clinical evidence, including measurements, indicating the infant's current cranial index of symmetry(CIS) is <83; and
- Current color photographs of the infant's head taken from the following views:
  - Superior;
  - Frontal;
  - Posterior; and
  - Right and left lateral
- Documentation from the treating orthopedic or craniofacial surgeon stating the treatment of using the cranial remolding orthosis is recommended due to poor improvement in the infant's CIS, after a documented six (6) months trial period of active counter positioning has been completed; and
- Six (6) months of documentation regarding daily counter positioning therapy.

Orthopedic Footwear

Medicaid may reimburse for orthopedic footwear when the following minimum requirements are met:

- The orthopedic footwear is prescribed by a licensed physician or podiatrist (D.P.M. or D.P.); and
- The participant has congenital foot deformities, including clubfoot in children;

- One of the participant's feet is full size and the other foot is one and one half times in length or two full widths larger than the other, and the participant requires a lift of one inch or more;
- The participant has a rigid foot deformity;
- The participant's foot or feet have severe structural deformities (e.g. rheumatoid arthritis, diabetic osteopathy or arthropathy, or following trauma);
- There are persistent skin breakdowns or ulcerations caused by such conditions as diabetic neuropathies or degenerative disorders when a total contact system on the sole is expected to promote healing and avoid hospital care and surgical intervention;
- The prescribed shoe is constructed by a licensed professional to provide support for a totally or partially missing foot; or
- The prescribed shoe is required in conjunction with an orthotic system.

Feeding Positioning Chairs

A feeding positioning chair is considered medically necessary for a recipient with an inability to maintain an unsupported sitting position independently during feeding which is caused by a medical condition such as any of the following (list is not all-inclusive):

- Severe head & trunk instability
- Severe hypotonicity, hypertonicity, spasticity or muscle spasm which results in uncontrollable movement and position changes
- Severe seizure activity that results in uncontrollable movement and position changes
- Orthopedic condition, such as curvature of the spine, which interferes with proper positioning

Coverage is provided for positioning feeding chairs when the following criteria are met:

- Participant requires significant postural support to maintain safe feeding*
- Positioning is needed to prevent reflux during feeding*

Documentation must include all of the following:

- An order for the feeding chair which is signed by the prescribing practitioner
- Justification which supports the medical appropriateness of the item ordered which includes face-to-face evaluation
- The participant's current height and weight, and the weight capacity for the requested chair.

*This chair is not approved for sitting at the table to eat. If the participant has a w/c with tilt and space, this item is considered a duplicate. The provider can request a tray for the chair.

Hospital Beds:

The DME Program considers hospital beds and accessories medically necessary DME for *any* participant that meets any of the following criteria:

1. The participant's condition requires positioning of the body (e.g., to alleviate pain, promote good body alignment, prevent contractures, or avoid respiratory infections) in ways not feasible in an ordinary bed; *or*

2. The participant's condition requires special attachments (e.g., traction equipment) that can only be attached to a hospital bed cannot be fixed and used on an ordinary bed; *or*

3. The participant requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered.

A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment.

Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed.

A semi-electric hospital bed is considered medically necessary if the participant meets one of the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position. A semi-electric bed is one with manual height adjustment and with electric head and leg elevation adjustments.

A heavy duty extra wide hospital bed is considered medically necessary if the participant meets one of the criteria for a fixed height hospital bed and the participant's weight is more than 350 pounds, but does not exceed 600 pounds. Heavy duty hospital beds are hospital beds that are capable of supporting a participant who weighs more than 350 pounds, but no more than 600 pounds.

An extra heavy-duty hospital bed is considered medically necessary if the participant meets one of the criteria for a hospital bed and the participant's weight exceeds 600 pounds. Extra heavy-duty hospital beds are hospital beds that are capable of supporting a participant who weighs more than 600 pounds.

Mattresses

The DME Program considers mattresses medically necessary DME only where the hospital bed is medically necessary. Note: A separate charge for replacement mattresses should not be allowed where the hospital bed with mattress is rented.

If a participant's condition requires a replacement innerspring mattress or foam rubber mattress, it may be considered medically necessary for a participant-owned hospital bed.

Variable Height Feature

The DME Program considers hospital beds with a manual or electric variable height feature medically necessary DME for participants who meet the criteria for hospital beds set forth above and who have *any* of the following conditions:

- Severe arthritis and other injuries to lower extremities (e.g., fractured hip, where the variable height feature is necessary to assist the participant to ambulate by enabling the participant to place his or her feet on the floor while sitting on the edge of the bed); *or*
- Severe cardiac conditions, where the participant is able to leave the bed, but who must avoid the strain of "jumping" up and down; *or*
- Spinal cord injuries (including quadriplegic and paraplegic participants), multiple limb amputees, and stroke participants, where the participant is able to transfer from a bed to a wheelchair, with or without help; *or*
- Other severely debilitating diseases and conditions, if the participant requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position.

A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments.

Powered Chair Conversion Feature

Electric chair positioning features are not covered since they are considered convenience features. Note: The TotalCare Bariatric Bed is an example of a bed with an electric chair positioning feature.

Built-in Weight Scale

A hospital bed with a built-in scale is considered medically necessary only for non-ambulatory individuals who require periodic weight measurements.

Electric Powered Hospital Bed Adjustments

The DME Program considers electric powered adjustments to lower and raise head and feet medically necessary DME for participants who meet the criteria for hospital beds set forth above and meet *both* of the following criteria:

Participant can operate the controls and cause the adjustments, *and*

Participant has a condition that requires frequent changes in body position and/or where there may be an immediate need for a change in body position (i.e., no delay can be tolerated).

Side Rails and Safety Enclosures

The DME Program considers safety enclosures for beds medically necessary DME only when the participant's condition places them at risk for falls or climbing out of bed is a concern and they are an integral part of, or an accessory to, a medically necessary hospital bed. A safety enclosure frame/canopy for use with a hospital bed is a safety enclosure used to prevent a participant from leaving the bed.

The DME Program considers bedside rails for beds medically necessary DME only when the participant's condition requires them and they are an integral part of, or an accessory to, a medically necessary hospital bed. Examples of conditions where bedside rails may be considered medically necessary include participants with seizures, vertigo, disorientation, and neurological disorders.

Ordinary (Non-Hospital) Beds

Note: Ordinary beds do not meet The DME Program's definition of covered DME, in that ordinary beds are not primarily medical in nature, are not primarily used in the

treatment of disease or injury, and are normally of use in the absence of illness or injury. An ordinary bed is one that is typically sold as furniture. It consists of a frame, box spring, and mattress. It is a fixed height, and has no head or leg elevation adjustments. An ordinary bed will accommodate most transfers to a chair, wheelchair, or standing position. If needed, it can almost always be adapted to accommodate these transfers. The need for a particular bed height would rarely by itself justify the need for a hospital bed.

The DME Program does not cover power or manual lounge beds because they are a comfort or convenience item. Note: In addition, power or manual lounge beds do not meet The DME Program's definition of covered DME, in that they are not primarily medical in nature, are not primarily used in the treatment of disease or injury, and are normally of use in the absence of illness or injury. These beds, like other ordinary beds, are typically sold as furniture. The following are examples of brands of lounge beds that do not fall within the definition of DME:

- Adjust-A-Sleep Adjustable Bed
- Adjustable firmness/support mattresses (e.g., Select Comfort/Sleep Number Bed)
- Craftmatic Adjustable Bed
- Electropedic Adjustable Bed
- Sealy Posturpedic Bed
- Simmons Beautyrest Adjustable Bed
- Visco-elastic or memory foam mattresses (e.g., Tempur-Pedic)
- Waterbed.

Institutional-Type Hospital Beds

Institutional-type hospital beds are inappropriate for home use. These include oscillating beds, springbase beds, circulating beds, cage beds, and stryker frame beds.

Beds that provide kinetic therapy or continuous lateral rotation therapy (e.g., Kinetic Therapy Triadyne Bed, Hill-Rom TotalCare SpO2RT) are considered experimental and investigational for prevention or treatment of pressure sores, because of a lack of evidence in the peer-reviewed medical literature of their effectiveness for that indication (AWMA, 2001; Cullum et al, 2001; Cullum et al, 2004). Beds that provide kinetic therapy or continuous lateral rotation therapy are considered experimental and investigational for long-term use outside of the acute-care hospital setting for preventing and treating pulmonary complications because the published peer-reviewed evidence of the effectiveness of these beds is limited to use in critically ill patients in the acute-care hospital setting.

Beds that provide vibration therapy or percussion therapy for preventing and treating pulmonary complications related to immobility are considered experimental and investigational because of a lack of adequate evidence in the peer-reviewed published medical literature of their effectiveness for this indication.

Pediatric Hospital Crib

The DME Program considers a pediatric hospital crib medically necessary when the child meets criteria for any of the aforementioned hospital beds.

- **Turning Bed:** The DME Program considers turning bed for the prevention of pneumonia and bedsores experimental and investigational because its effectiveness has not been established.
- **Enclosure Beds and Frame/Canopy Beds:** The Vail Enclosure Bed (Vail Products, Inc., Toledo, OH), a padded bed that is completely enclosed with netting, is considered experimental and investigational because the U.S. Food and Drug Administration has determined that this device poses significant safety risks.

Note: The DME Program does not provide coverage of safety beds (SleepSafe Beds), enclosure beds (e.g., Posey Bed Enclosure Safety System; Vail Enclosure Bed) or a frame/canopy for use with a hospital bed and limb restraints as they are considered non-covered safety items. The DME Program covers medically necessary services and supplies for the "*diagnosis, care or treatment*" of disease or injury. Although restraints, helmets, safety straps, etc., may prevent injury, they are not considered *care or treatment* of disease or injury. In addition, such safety items are specifically excluded from coverage.

Specialty Mattresses

Low Air Loss Mattress (group 2 pressure reducing support surface with inflated cell depth of at least 5 inches)*

One of the following conditions must be met:

- The participant has more than one stage 2 ulcers on the trunk and no surface area of the body that is sufficiently free of ulcers and can support the body weight to permit safe turning; or
- The participant has one stage 3 ulcer on the trunk and is limited to one or no surface area of the body that is sufficiently free of ulcers and can support the body's weight to permit safe turning.

Air Fluidized Bed (air fluidized bed approved as a group 3 pressure reducing support surface)*

One of the following conditions must be met:

- The participant has more than one stage 3 ulcers and/or at least one stage 4 ulcers on the trunk and is limited to one or no surface area of the body that is sufficiently free of ulcers and can support the body weight to permit safe turning; or
- The participant is in the initial 60 days of post-operative recovery from myocutaneous flap or graft surgery for a decubitus ulcer on the trunk.

Documentation must include all of the following:

1. An order for the bed or mattress which is signed by the prescribing practitioner
2. Justification which supports the medical appropriateness of the item ordered, which includes a face-to-face evaluation.

* Support surfaces that meet the above criteria are rented in increments of 3 months (up to ten) to ensure that the surface is beneficial to the participant. If the participant's condition improves, and is still needed after ten months, the item is considered purchased.

Parenteral and Enteral Nutrition (PEN) Items and Services

Telligen completes reviews for Maryland Medicaid participants who request PEN services. This review is conducted to determine eligibility, medical necessity, utilization and/or continuation of medical need for the items provided to Maryland Medicaid participants to support their independence in their home, school, place of employment, and other community settings, when appropriate.

The objective is to ensure that Maryland Medicaid participants have access to cost-effective parenteral and enteral nutrition (PEN) services that meet their health needs in the home, school, place of employment, community settings, and other settings, when appropriate

A complete PEN Authorization form must be submitted with all initial, revised, and recertification requests

The provider has 20 business days to request that Telligen reconsider (initial, revised, or recertification) decisions to deny or partially deny their request

Medical Necessity Clinical Criteria for Enteral Nutrition

Clinical review for enteral nutrition is a retrospective process. Providers are required to submit all clinical justification to the Department's Utilization Control Agent (UCA) every 12 months, or for a change in prescription. The UCA will perform retrospective reviews to ensure medical necessity of all requests.

Enteral nutrition is defined as a nutritional product given by a nasogastric, gastrostomy or jejunostomy tube that can be provided safely in a non-hospital setting. Enteral nutrition is considered reasonable and medically necessary for a participant with a permanent impairment such as a non-function or disease of the structures that normally permit food or other nutritional products to reach the stomach or small intestine; or disease of the small or large intestine that does not allow for digestion or absorption of an oral diet, either of which requires tube feedings to provide nutrients to maintain growth and weight according to the participant's health status.

Enteral Nutrition may be consider medically necessary if medical records demonstrate:

- Permanent impairment is defined as a condition that will not improve in less than 3 months or 90 days or the judgment of the attending physician, indicating that the impairment will be of long and indefinite duration.
- Hospital records which specify participant's condition such as:
- Anatomical abnormalities (i.e. obstruction due to head and neck cancer or reconstruction surgery, among others) OR
- Motility disorders (ie severe dysphagia following a stroke, neuromuscular disorders of the CNS, among others); AND
- Signed and dated prescriber order including documentation that a face-to-face encounter occurred within 6 months before ordering services (initial and subsequent orders); [COMAR 10.09.12.04 E (1)(a)] AND
- Sufficient medical documentation that enteral nutritional product is requested to maintain weight and strength commensurate with overall health status which is not possible by dietary adjustment and/or oral supplements. This should include medical records from the attending physician or practitioner such as clinic notes with clear diagnosis and plan of treatment.

Enteral feeds will not be approved for disorders that include psychiatric reasons such as anorexia or bulimia and other mood disorders. Enteral feeds will not be approved for the use in end stage disease, such as terminal cancer or advanced dementia.

- Documentation of an inborn error of metabolism as justification for the request for the Special Nutrients Formula for which the formula is known to be specifically used, regardless of the route of administration.
- Documentation of the percentage of calories taken by tube feeds: Approval can be granted for nutritional supplements up to the amount that corresponds to the documented percentage of calories taken by tube feeding nutrition.
- If the member is 100% tube fed, the total calories provided from all nutritional supplements should not exceed 100% of participant's total daily caloric requirement.
- If the member is 50 % tube fed, the total calories provided from all nutritional supplements should not exceed 50% of participant's total daily caloric requirement.
- If the participant is receiving more than one kind of nutritional supplement, calories derived from each supplement must be documented separately. The values for all supplement feeds should equal the value of the total percentage of calories taken by tube feeding (e.g., if the participant is 50% tube fed, the quantity approved should provide no more than 50% of total calories required per day for all nutritional supplements combined).
- Explanation when the use of a pump is medically necessary DME, in situations when gravity feedings or syringe feedings have caused complications or are otherwise not indicated due to:
    - Reflux and/or aspiration
    - Severe diarrhea
    - Dumping syndrome
    - Administration less than 100 ml/hr
    - Blood glucose fluctuations
    - Circulatory overload
    - Gastrostomy or Jejunostomy tube used for feeding

Audiology Reviews

This section covers the requirements for requests for hearing aids, cochlear implants and BCROS/CROS.

Hearing Aids

Clinical Coverage Criteria for Hearing Aid Coverage in Children

- The Maryland Medicaid Program considers bilateral or unilateral hearing aids medically necessary for participants up to age 21 years when the following criteria are met:
    - The participant has a hearing loss of 25 dB or greater; AND
    - Hearing aid(s) recommended and fitted by an audiologist; AND
    - For initial hearing aid(s), written medical clearance is obtained from a physician who has performed a medical examination within the past 6 months

Clinical Coverage Criteria for Hearing Aids in Adults

- Unilateral hearing aids are considered medically necessary for participants 21 years of age and older when the following criteria are met:
    - The participant has a pure tone average threshold of 40 dB or greater at 500, 1000, 2000 and 3000 Hz in the better ear; AND
    - Documentation that patient is alert and able to utilize their aid appropriately; AND
    - Hearing aid is recommended and fitted by an audiologist; AND
    - For initial hearing aid, written medical clearance from a physician who has performed a medical examination within the past 6 months.

Bilateral hearing aids are considered medically necessary in recipients 21 years of age and older who meet the criteria for unilateral hearing aids and when one of the following criteria are met:

- The participant has visual impairment meeting the definition of statutory blindness; OR
- The participant is a previous successful bilateral hearing aid user and meaningful objective benefit to the participant over unilateral amplification can be documented; OR
- The participant demonstrates significant hearing-related disability in educational , vocational, or community settings with a unilateral aid and meaningful objective benefit from bilateral aids can be documented.

Cochlear Implants

Clinical Coverage Criteria for Cochlear Implantation in Children

- For children 9 months – 20 years, the Maryland Medicaid Program considers unilateral or bilateral implantation of a cochlear implant medically necessary when the following criteria are met:
  - Bilateral severe to profound pre- or post-lingual sensorineural hearing loss, defined as a pure tone average threshold of 70 dB or greater at 500, 1000, and 2000 Hz; AND
  - A minimum 3 to 6 month trial with appropriate binaural hearing aids has occurred if child is not previously experienced with hearing aids (radiologic evidence of cochlear ossification may justify a shorter trial with amplification); AND
  - Limited or no benefit from appropriate binaural hearing aids, defined as:
  - In younger children, lack of progress in the development of simple auditory skills in conjunction with hearing aids over a 3 to 6 month period, quantified on a measure such as the Meaningful Auditory Integration Scale or the Early Speech Perception test.
  - In older children, < 30% correct on the Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT) depending upon the child's cognitive ability and linguistic skills; AND
  - Documentation that the child and parent/guardian are willing and able to participate in a post-cochlear implant rehabilitation program in order to achieve benefit from the cochlear implant device; AND
  - Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system; AND
  - No contraindications to surgery.

Clinical Coverage Criteria for Cochlear Implantation in Adults

- For participants 21 years and older, unilateral implantation of a cochlear implant is considered medically necessary when the following criteria are met:

- Bilateral severe to profound pre- or post-lingual sensorineural hearing loss, defined as a pure tone average threshold of 70 dB or greater at 500 Hz, 1000 Hz, and 2000 Hz; AND
- Limited benefit from appropriate hearing aids, defined as scoring 50% or less in best-aided listening condition on a test of open-set sentence recognition (ex. HINT Sentences); AND
- The participant is willing and able to participate in a post-cochlear implant rehabilitation program in order to achieve benefit from the cochlear implant device; AND
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system; AND
- No contraindications to surgery.

Bone-anchored Hearing Aids (Auditory Osseointegrated Devices)

Clinical Coverage Criteria for Bone-anchored Hearing Aids (BAHA) in Children and Adults

- The Maryland Medicaid Program considers bone-anchored hearing aids medically necessary for participants 5 years and older (and non-implantable or softband devices for participants less than 5 years or as clinically indicated) when the following criteria are met:
  - Unilateral implant: conductive or mixed hearing loss with a pure tone average bone conduction threshold at 500, 1000, 2000, and 3000 Hz that is less than or equal to 45 dB (BAHA Attract, BAHA Divino, BAHA BP100, Baha 4 and Sophono Alpha System), 55 dB (BAHA 5 Power, BAHA Intenso, Ponto Plus Power) or 65 dB (BAHA Cordelle II); or
  - Bilateral implants: moderate-to-severe bilateral symmetric conductive or mixed hearing loss, meeting above-listed bone conduction thresholds in both ears; symmetric bone conduction threshold is defined as less than:
  - 10 dB average difference between ears (measured at 500, 1000, 2000 and 4000 Hz) or less than 15 dB difference at individual frequencies (BAHA Divino, Ponto Plus, Ponto Plus Power, Ponto Pro, Sophono Alpha System); or
  - 10 dB average difference between ears (measured at 500, 1000, 2000 and 3000 Hz), or less than a 15 dB difference at individual frequencies

(BAHA Attract, BAHA BP100, BAHA 4, BAHA 5 Power, BAHA Cordelle II, BAHA Intenso); AND

- For unilateral or bilateral implants, participant has one of the following medical conditions preventing use of a conventional air conduction hearing aid:
- Congenital or surgically induced malformations (e.g., atresia) of the external or middle ear canal; or
- Severe chronic external otitis or otitis media; or
- Tumors of the external ear canal and/or tympanic cavity; or
- Dermatitis of the external ear canal, including hypersensitivity to ear molds used in air conduction hearing aids; or
- Other anatomic or medical conditions that contraindicate the use of an air conduction hearing aid.

The Maryland Medicaid Program considers a bone-anchored hearing aid medically necessary for participants 5 years and older with unilateral sensorineural hearing loss (single-sided deafness) and normal hearing (a pure tone average hearing threshold of <20 dB) in the other ear.

Air Ambulance

The objective is to ensure that Maryland Medicaid participants have access to Rotary Wing (RW) air ambulance services when medically necessary and appropriate. Telligen staff review and determine the medical necessity and appropriateness for RW air ambulance services.

Telligen completes reviews for Maryland Medicaid participants when requested by licensed, RW air ambulance providers in good standing with the Maryland Medicaid Program. This review is conducted to determine the medical necessity and appropriateness of rotary wing air transportation

The intention is to ensure that the air transport has not occurred as a result of a request from a "911" system nor from the 'scene' of an accident or incident, not otherwise covered by another payer; that ground transport is contraindicated due to the critical medical condition of the participant, the ground transport time to the receiving hospital exceeds 30 minutes from the sending facility when the participant is in need of a time sensitive intervention, transportation to the receiving hospital is for a service or specialty not available at the sending facility, and transfer

to the receiving facility is not for the preference or convenience of the participant nor provider.[1]

The following documentation must be submitted with an Air Ambulance request:

- Physician Certification Form for Maryland Medicaid Air Transportation-fillable form found at: https://health.maryland.gov/mmcp/communitysupport/Documents/Provider-Certification-Form-Air-Ambulance-Transport-2024.pdf
- CMS 1500 Claim Form
- Sending facility Patient Demographics/Face Sheet
- Patient medical records from the sending facility. This should include
  a. Discharge/Transfer Summary
  b. Disposition necessitating transfer
  c. Reason for selected destination facility
  d. Reason transportation by ground is contraindicated
  e. Patient Care Report and in-flight medical record from RW Provider

The physician's order for the authorization should be signed within 30 calendar days of the date of service

The provider has 20 business days to request that Telligen reconsider an initial decision to deny or partially deny their request

Air Ambulance Criteria

General Requirements for Air Transportation Providers

- Providers shall, to the extent required by law, be licensed and legally authorized to provide this service in the state where the transport occurs; and
- Providers shall be active providers in good standing with the Maryland Medicaid Program.

In order for a provider to receive Medicaid reimbursement for rotary wing air transportation, the following conditions shall be met:

- The individual is a Maryland Medicaid Participant;
- The receiving hospital/facility is a Maryland Medicaid Provider;

[1] Telligen provides a help line for air ambulance-related questions through the Telligen support center. Providers can call 888-276-7075, option - #2). For website support, see the Education & Training and FAQs sections at www.telligenmd.qualitrac.com.

- The service to be rendered at the receiving hospital is covered by Maryland Medicaid;
- The service for which the participant is being transferred is not available at the sending facility;
- Air transportation is medically necessary and appropriate
- The air transport has not occurred as a result of a request from a "911" system, and is not otherwise covered by another payer, AND
- The ground transport time to the receiving hospital exceeds 30 minutes from the sending facility and transportation by ground is contraindicated.
- The treating physician from the sending hospital/facility has completed a Physician Certification Form for Maryland Medicaid Air Transportation;
- The receiving hospital has agreed to accept the participant;
- The receiving hospital is the closest appropriate provider;
- Transfer is not primarily for the convenience of the participant or provider; and
- Criteria for medical necessity and appropriateness. Rotary wing transport is considered medically necessary and appropriate when all the following conditions are met:
    - The participant requires services that the sending hospital/facility is not able to provide,
    - The receiving hospital has the services required by the participant,
    - The receiving hospital is the one closest to the sending hospital that has the services required by the participant,
    - The receiving hospital agrees to accept the participant, and
    - The participant's medical condition is such that using ground transportation can reasonably be expected to result in placing the participant's health in further jeopardy

Long-Term Services and Supports (LTSS) Reviews

The following section provides information about reviews covered by Long-Term Services and Supports.

Nursing Facility Level of Care Medical Eligibility Reviews

In order to receive Medicaid benefits for services in a nursing facility an individual must meet certain medical eligibility criteria under the Maryland Medicaid

program. Telligen utilizes criteria set forth in both federal and state regulations, as well as in specified Maryland Medicaid provider transmittals, to determine if eligibility criteria is met.

Criteria used for determining eligibility is COMAR 10.09.01B, COMAR 10.09.10.06B, and Nursing Home Transmittals 213 and 237.

Documentation submitted with the NF LOC request should include the following:

- A complete 3871 – either electronically in the Qualitrac system or an uploaded paper copy.
- An OT and/or PT evaluation and progress notes, if applicable
- History and Physical
- Most recent physician progress note
- Most recent therapy notes
- BIMS score
- Ensure an electronic Level I PASRR is on file
- Level II PASRR clearance, if needed

Providers have 5 days to respond to a Request for Information. Providers have 20 business days to submit a reconsideration request.

Level of care may be processed in Qualitrac by the 3871B from hospitals and nursing facilities or in LTSSMaryland by the interRAI from the local health departments. Determinations made as a result of either process are valid for the purposes of admitting a person to a nursing facility under Medicaid, provided complete PASRR documentation has been supplied.

Nursing Facility Level of Care Continued Stay Reviews

All Medicaid nursing facility residents must meet the nursing facility level of care (LOC) criteria set by the Department. Continued Stay Reviews (CSRs) must occur no less often than quarterly for the first year following the initial level of care approval. After the first year following the initial level of care approval, CSRs must be conducted annually.

Facilities will be notified/reminded by Telligen via Qualitrac to actively submit a NF CSR according to the participant's quarterly or annual due date. Triggered alerts (or tasks) will be on set intervals based on the initial eligibility start (or transfer) date.

The trigger for the provider should always be 60 days ahead of when the CSR is due. Where a (CSR) is due by the Xth day from the eligibility start/transfer date of:

First Quarter (90th day),

Second Quarter (180th day),

Third Quarter (270th day),

Fourth Quarter (360th day) and then

Annually thereafter. For example, the first annual is due by the 730th day (anniversary date + 1 year).

Reminder Notifications. The Authorized Official will receive an email 60 days prior to the due date of the CSR that the CSR or the discharge status needs to be completed. The Authorized Official will receive reminder emails every 10 calendar days up until the due date of the CSR. The request task and the discharge status task will remain on the provider's task queue, and the Department will get a report monthly of any CSRs that were not submitted.

Provider Response. If the provider receives a task to complete a CSR, they may respond by:

Completing the CSR any time prior to the due date to be considered on time.

Or completing the Discharge status task to indicate any of the following:

Reporting that the participant has discharged.

Reporting that the participant transferred to a new facility.

Reporting that the participant has passed away.

Reporting Other - with explanation.

A summary of LOC needs will be captured by an electronic questionnaire based on the MDH 3871b and uploaded documentation in Qualitrac.

Criteria used for CSRs is the following:

COMAR 10.09.10.01B; COMAR 10.09.10.06B; Nursing Home Transmittals 213 and 237

Special Pediatric Medical Eligibility and Continued Stay Reviews

The purpose is to review initial eligibility for special pediatric hospital services. An initial request for special pediatric authorization may occur for several reasons including a transition from an acute care hospital. An initial authorization for special pediatric hospitals is for 14 days.

For participants transitioning from a Medicaid Managed Care Organization (MCO) to the Medicaid fee-for-service program, the MCO period will end at 90 days. Providers are required to make an initial level of care request on day 75 for transition to fee-for-service payment

Documentation should include at a minimum:

History and Physical, most recent progress notes, labs, imaging results, PT, OT, and other therapy notes.

The objective for special pediatric CSRs is to review continued eligibility for special pediatric hospital services. If the patient requires ongoing treatment past the initial approval period from admission or conversion to Medicaid (whichever occurs later), special pediatric hospitals are required to submit documentation to support a continued stay.

This request is due on the last day of the approved period. The provider may submit this request within three days of the due date (before or after).

If the facility does not request a CSR, the resident's eligibility length of stay will not be extended, and the facility **will not be able** to bill for those days.

If the facility submits an untimely request, Telligen must review the request based on the date of submission onward. If approved, the approved dates would be for 14 days from that date. Telligen may not retroactively approve cases not submitted timely, unless directed to do so by the Department. When the request for continued stay is not timely, those days may not be billed.

Each continued stay after the initial is approved for 14 days. The provider, subsequently, must submit documentation for continued stay every 14 calendar days from the last day of the previously approved period.

Documentation for CSRs should include at a minimum History and Physical, most recent two weeks of progress notes, labs, imaging results, PT, OT, other therapy notes and documented physician intervention at least three times weekly

Adult Chronic Medical Eligibility and Continued Stay Reviews

The purpose is to review initial eligibility for adult chronic hospital services. An initial request for ric adult chronic authorization may occur for several reasons including a transition from an acute care hospital. An initial authorization for chronic hospitals is for 30 days. Each continued stay after the initial is approved for 14 days. The provider, subsequently, must submit documentation for continued stay every 14 calendar days from the last day of the previously approved period.

Documentation should include at a minimum:

History and Physical, most recent progress notes, labs, imaging results, PT, OT, other therapy notes, and the DHMH 3871.

The objective for adult chronic CSRs is to review continued eligibility for adult chronic hospital services. If the patient requires ongoing treatment past the initial approval period from admission or conversion to Medicaid (whichever occurs later), adult chronic hospitals are required to submit documentation to support a continued stay.

This request is due on the last day of the approved period. The provider may submit this request within three days of the due date (before or after).

If the facility does not request a CSR, the resident's eligibility length of stay will not be extended, and the facility **will not be able** to bill for those days.

If the facility submits an untimely request, Telligen must review the request based on the date of submission onward. If approved, the approved dates would be for 14 days from that date. Telligen may not retroactively approve cases not submitted timely, unless directed to do so by the Department. When the request for continued stay is not timely, those days may not be billed

Each continued stay after the initial is approved for 14 days. The provider, subsequently, must submit documentation for continued stay every 14 calendar days from the last day of the previously approved period.

Documentation for CSRs should include at a minimum History and Physical, most recent two weeks of progress notes, labs, imaging results, PT, OT, other therapy notes and documented physician intervention at least three times weekly

Level I PASRR Reviews

The objective is to ensure Maryland Nursing Facility participants are not inappropriately placed in nursing facilities for long-term care. This is based on Federal Requirements 42 CFR PART 483 §483.100-138 and COMAR 10.09.10.03/

PASRR requires all Medicaid-certified Nursing facilities that receive an admission for NF placement regardless of payer source will enter Level 1 PASRR information into Qualitrac. The review is conducted to evaluate the applicant for serious mental illness (SMI) and/or intellectual disability(ID), offer all applicants the most appropriate setting for their needs, and ensure all applicants have the services they require.

Auto Auth rules are configured within the Qualtrac request. If the answers indicate a negative or exempt PASRR the request will be approved for the level 1 request within Qualitrac. If any answers indicate a potentially positive PASRR the review will be pended to the LTC Qualitrac queue for nurse review. If the Level I screen indicates that a Level II evaluation is necessary, a Categorical Advance Group Determination (CAGD) Form or Level II clearance form from either the Developmental Disabilities Administration (DDA) or the Behavioral Health Administration (BHA) should be uploaded to the request.

If PASRR is positive or information in the 3871B or other supporting documentation indicate that the PASRR should be positive, the hospital or NF must obtain a Level II clearance form from either the Developmental Disabilities Administration (DDA) or the Behavioral Health Administration (BHA), and the facility must contact the local health department AERS unit to begin that process.

Hospice Reviews for beneficiaries on their 6th or more benefit period

Telligen conducts a medical review of patients who are beginning their 6th benefit period, to determine whether the patient continues to have a terminal condition as defined by State and federal regulations.

According to COMAR 10.09.35.01B(28): "Terminally ill" means that the individual has a medical prognosis of a life expectancy of 6 months or less if the illness runs its normal course.

The criteria used for making the determination of whether the member remains appropriate for hospice is the Medicare Local Coverage Determinations (LCD) for terminal diagnosis and the End of Life Guidelines by MCG as supported with the following information:

Records of histories & physical examinations, laboratory tests, physician notes, nurses' notes, notes from social workers and other professionals, consultations, medications, and other documentation that establishes that the patient continues to demonstrate a decline and has a medical prognosis of a life expectancy of 6 months or less if the illness runs its normal course.

Interviews with the staff and others caring for the patient, as appropriate.

If for any patient the medical record review does not support the terminal condition, Telligen staff may conduct an onsite interview with staff, the patient and/or family.

The provider has 20 business days to request that Telligen reconsider a decision to deny their request.

Home and Community-Based Services (HCBS)

Medical Adult Day Care (MADC)

The purpose of this review is To determine if a participant meets the medical eligibility criteria for Medical Adult Day Care (MADC or MDC).

All reviews for the Medical Adult Day Care require that the participant completes the Medical Eligibility Questionnaire. The provider may also be required to submit additional information, such as a letter from a physician, before the case is approved or denied. Approved medical eligibility review for initial Medical Adult Day Care requests is for 120 days.

Redetermination requests are processed in the LTSSMaryland system. If it is a redetermination, only AERS or the MADC center should complete the request in LTSSMaryland.

Providers have 10 Business days to submit this information. This may include but is not limited to information regarding recent hospitalizations, medical consultations, discharge summaries and the most current documentation regarding the individual's ability to perform their own ADL's.

Therapy notes including frequency, length of visits and progress toward goals may be requested. Current physician orders and notes, social work and case manager notes and any other pertinent documentation that supports requested level of care, should all be submitted.

Criteria is from COMAR 10.09.07; Nursing Home Transmittals #213 and #237

Brain Injury (BI)

This review is to determine chronic level of care or nursing facility level of care. These reviews are submitted and completed in MD LTSS and/or Qualtrics.

In MD LTSS:

Submitters have 10 days to respond to a request for additional information. Information may include but is not limited to: Physician and consult notes, social work notes or case management notes, any documentation regarding ability to perform ADL's and any other documentation that supports requested level of care.

In Qualitrac:

If the request for Brain Injury Waiver Access LOC is submitted by a hospital through the Qualitrac portal, it will come in as a request for medical eligibility review. The "Type" of review in Qualitrac will be "Adult Chronic." The 3871 and supporting documents will identify that this is a Brain Injury request.

Criteria

COMAR 10.09.46 and Nursing Home Transmittals No. 213 and 237

Model Waiver (MW)

The objective of these reviews is To determine if a participant meets the medical eligibility criteria for the Home Care for Disabled Children Under a Model Waiver (Model Waiver or MW). These reviews are submitted in LTSS Maryland.

The submitter will indicate their LOC details, any comments, and their requested eligibility start date in the MW Level of Care Request section. The 3871 or 3871B form, along with any supporting documentation, will be uploaded as an attachment to this module.

Criteria

All Model Waiver reviews require the participant to complete the Medical Eligibility Questionnaire (Form 3871 or 3871B). The provider may also be required to submit additional information, such as a letter from a physician, before the case is approved or denied.

Chronic Level of Care

The initial chronic level of care is given to an individual requires 24 hour around the clock care on a Ventilator, to ensure their safety at home or community setting. This level is also given if an individual has a neurological or neuromuscular condition which is progressing and can compromise his/her respiratory status and already is on non-invasive mode of respiratory support such as BiPAP and CPAP, or has undergone a tracheostomy and is expected to required mechanical ventilation in the near future. It is important that this individual and family have support to ensure safety in the community.

Recertification of chronic level of care is provided when the individual that has been previously certified has a respiratory condition, has been followed by a pulmonologist and their condition is not expected to improve. Respiratory improvement is defined as decreasing the ventilator support, weaning mechanical ventilation to CPAP or BiPAP, increase of use of the passy muir valve and Decannulation.

Nursing Facility Level of Care

Initial and Recertification- The individual requires care to avoid institutionalization that cannot be provided by another insurance, Medicaid or EPSDT, in a safe manner. This may include services such as

- Initial private duty nursing to establish safe Total Parenteral Nutrition (TPN) or a chronic condition such as short bowel syndrome,
- Initiation of enteral feedings through recently placed enteral tubes on individuals unable to feed themselves or who have severe reflux disease and are at an increased risk of aspiration pneumonia for a limited amount of time.
- Safety for individuals who required a tracheostomy because he/she requires a patent airway with suctioning several times a day.

- The individual requires PDN for the initiation of Non-invasive respiratory support such as CPAP or BiPAP that requires continued monitoring of his/her oxygenation at the beginning of this treatment.
- CMT/ CNA/Home Health Aides for individuals that have a neurological or neuromuscular disorder who requires hands on assistance with ADL's on a regular bases (but not intermittently);
- CMT/ CNA/Home Health Aides cueing or supervision to perform ADL's for individuals who have an intellectual disability or requires redirection and monitoring their behaviors

Program of All-Inclusive Care for the Elderly (PACE)

In order to receive Medicaid benefits for services in the Program of All-Inclusive Care for the Elderly (PACE), an individual must meet certain medical eligibility criteria under the Maryland Medicaid program. Telligen utilizes criteria set forth in both in federal and state regulations, as well as in specified Maryland Medicaid provider transmittals, to determine if eligibility criteria is met.

NOTE: Requirements for Pre-Admission Screening and Resident Review (PASRR) do not apply to requests to enroll in PACE.

The provider has 10 calendar days to respond to any requests for additional information. Initial reviews are approved for 365 days.

Recertification

The review process for recertification is the same as for Initial Application above, except that if the submitted information does not support that the participant meets nursing facility criteria and the case is referred to Peer Review, the Medical Director/Physician Advisor may approve the case if the participant meets "deeming" criteria, i.e. in the absence of the PACE program the participant would likely meet nursing home level of care in six months. One of the following must be present:

a) Cognitive impairment with a BIMS of 9 or less

b) Medically complex needs requiring at least weekly intervention from a healthcare provider

c) History of two or more hospitalizations or ER visits in the two months prior to PACE participation, or

d) Psychiatric diagnoses requiring on-going and frequent intervention by PACE.

Only one annual recertification is required. If the participant is found to be medically eligible for continued PACE services, no more recertifications are necessary.

COMAR References and/or Transmittals

COMAR 10.09.44.05A; Nursing Home Transmittals #213 and 237; PACE Transmittal #2