Provider Standards & Procedures

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Provider Rights, Responsibilities and Roles

Provider Rights

Providers have a right to

- Be treated by associates and covered dependents and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for associates' and covered dependent's care
- Have associates and covered dependents act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital or other offices running smoothly
- Expect other network providers to act as partners in associates' and covered dependent's treatment plans
- Expect associates and covered dependents to follow their directions, such as taking the right amount of medication at the right times
- Help associates and covered dependents make decisions about their treatment, including the right to recommend new or experimental treatments
- Make a complaint or file an appeal against the MedStar Select Health Plan and/or an associate or covered dependent
- Receive copayments, coinsurance and deductibles as appropriate
- File a grievance with MedStar Select on behalf of an associate or covered dependent
- Have access to information about MedStar Select's Quality Improvement programs, including program goals, processes and outcomes that relate to associate care and services. This includes information on safety issues.
- Contact Provider Services with any questions, comments or problems, including suggestions for changes in the Quality Improvement Program's goals, processes and outcomes related to associate and covered dependent care and services

Provider Responsibilities

Providers have a responsibility to

- Treat associates and covered dependents with fairness, dignity and respect
- Not discriminate against associates or covered dependents on the basis of race, color, sex, gender identity, sexual orientation, national origin, disability, age, religion, mental or physical disability or limited English proficiency
- Maintain the confidentiality of associates' and covered dependent's personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give associates and covered dependents a notice that clearly explains their privacy rights and responsibilities as they relate to the provider's practice/office/facility
- Provide associates and covered dependents with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow associates and covered dependents to request restriction on the use and disclosure of their personal health information

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- Provide associates and covered dependents, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to associates and covered dependents in a language they can understand about their health condition and treatment, regardless of cost or benefit coverage, and allow the associates and covered dependents to participate in the decision making process
- Tell an associate or covered dependent if the proposed medical care or treatment is part of a research experiment and give the associate or covered dependent the right to refuse experimental treatment
- Allow an associate or covered dependent who refuses or requests to stop treatment the right to do so, as long as the associate or covered dependent understands that, by refusing or stopping treatment, the condition may worsen or be fatal
- Respect associates' and covered dependent's advance directives and include these documents in the associates' and covered dependent's medical record
- Allow associates and covered dependents to appoint a parent, guardian, family member or other representative if they cannot fully participate in their treatment decisions
- Allow associates and covered dependents to obtain a second opinion and answer their questions about how to access healthcare services appropriately
- Collaborate with other healthcare professionals who are involved in the care of the associate or covered dependent
- Obtain and report to MedStar Select information regarding other insurance coverage
- Follow all state and federal laws and regulations related to patient care and patient rights
- Participate in MedStar Select data collection initiatives, such as HEDIS™ and other contractual or regulatory programs
- Review clinical practice guidelines distributed by MedStar Select
- Comply with the MedStar Select Medical Management program as outlined in this manual
- Notify MedStar Select in writing if the provider is leaving or closing a practice
- Contact MedStar Select to verify associate or covered dependent eligibility or coverage for services, if appropriate
- Disclose overpayments or improper payments to MedStar Select in accordance with timeframes outlined in applicable laws and regulations
- Invite associates and covered dependents to participate, to the extent possible, in understanding any medical or behavioral health problems that they may have to develop mutually agreed upon treatment goals, to the extent possible
- Provide associates and covered dependents, upon request, with information regarding office location, hours of operation, accessibility and languages, including the ability to communicate with sign language
- Provide associates and covered dependents, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency and board certification status
- Treat associates and covered dependents with respect and dignity no matter their race, national origin, age, color, creed, marital status, ancestry, political beliefs,

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personal appearance, sex, gender identity, sexual orientation, religion, gender, physical or mental disability or type of illness or condition

- Provide associates and covered dependents access to care no matter their race, national origin, age, color, creed, marital status, ancestry, political beliefs, personal appearance, sex, sexual orientation, religion, gender identity, physical or mental disability or type of illness or condition

Provider Role in Compliance

MedStar Select Health Plan must comply with applicable federal and state laws, regulations and accreditation standards in order to operate as a licensed health insurer. In order to meet these requirements, as well as combat cost trends in the healthcare industry such as fraud, abuse and wasteful spending, MedStar Select established its distinct Compliance Program.

The MedStar Select Compliance Program serves to assist contracted providers, staff members, management and our board of directors with promoting proper business practices. Proper business practices include identifying and preventing improper or unethical conduct.

Reporting Compliance Concerns and/or Issues

There is a help line for contracted providers, vendors, associates and covered dependents and other entities to call in order to report compliance concerns and/or issues without fear of retribution or retaliation. The MedStar Health Integrity Hotline's number is **877-811-3411**. It is available 24 hours a day, 7 days a week. Callers may remain anonymous. Compliance concerns include, but may not be limited to, issues related to the Health Insurance Portability and Accountability Act (HIPAA); the Gramm-Leach-Bliley Act; Fraud, Waste, & Abuse; and the Americans with Disabilities Act (ADA).

Responsibilities of Providers with Regard to Compliance

- All contracted providers are expected to conduct themselves according to the MedStar Health Code of Conduct & Ethics.
- All contracted providers have a duty to immediately report any compliance concerns and/or issues.
- All contracted providers should be alert to possible violations of the law, regulations and/or accreditation standards, as well as to any other type of unethical behavior.
- MedStar Select prohibits retaliation against providers or any affiliates who raise, in good faith, a compliance concern and/or issue or any other question about inappropriate or illegal behavior.
- MedStar Select prohibits retaliation against providers or any affiliates who participate in an investigation or provide information relating to an alleged violation.

The success of MedStar Select's Compliance Program relies in part upon the actions taken by our contracted providers. It is critical for our contracted providers to be aware of the goals and objectives of the Compliance Program, as well as of their responsibilities as providers.

For any questions regarding MedStar Select's Compliance Program and/or a contracted provider's responsibilities, please call the MedStar Health Integrity Hotline at **877-811-3411.**

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Provider Role in HIPAA Privacy & Gramm Leach-Bliley Act Regulations

All MedStar Select policies and procedures include information to make sure the plan complies with the Health Insurance Portability and Accountability Act (HIPAA) regulations and the Gramm-Leach-Bliley Act.

Hospitals and providers subject to HIPAA are trained to understand their responsibilities under these privacy regulations, as is the staff at MedStar Select.

MedStar Select has incorporated measures in all of its departments to make sure potential, current and former associates' and covered dependent's personal health information, individually identifiable health information and personally identifiable financial information are maintained in a confidential manner, whether that information is in oral, written or electronic format. MedStar Select employees may use and disclose this information only for those purposes permitted by federal law or regulation (e.g., for treatment, payment and healthcare operations); by the associate's or covered dependent's written request; or if required to disclose such information by law, regulation or court order.

A form authorizing the release of personal health information is available from MedStar Select's Member Services department or from the MedStar Select website. This form complies with the core elements and statements required by HIPAA privacy rules. This form must be completed, signed and returned to MedStar Select before the release of information.

All associates and covered dependents receive MedStar Health's Privacy Statement and Notice of Privacy Practices in their welcome kit materials. Associates and covered dependents also receive a copy of this privacy information annually. These documents clearly explain the associates' and covered dependents' rights concerning the privacy of their individual information, including the processes that have been established to provide them with access to their protected health information and procedures to request to amend, restrict use and receive an accounting of disclosures. The documents further inform associates and covered dependents of MedStar Select's precautions to conceal individual health information from employees.

MedStar Health's Notice of Privacy Practices is separate and distinct from the Notice of Privacy Practices that providers are required to give to their patients under HIPAA. The MedStar Health Notice of Privacy can be viewed at **www.MedStarProviderNetwork.com**.

Provider Role in ADA Compliance

Providers' offices are considered places of public accommodation and, therefore, must be accessible to individuals with disabilities. Providers' offices are required to adhere to the Americans with Disabilities Act (ADA) guidelines, Section 504 of the Rehabilitation Act of 1973, and other applicable laws. Providers may contact Provider Services at **855-222-1042** to obtain copies of these documents and other related resources.

MedStar Select requires that network providers' offices or facilities comply with these authorities. The office or facility should be wheelchair-accessible or have provisions to accommodate people in wheelchairs. Please check the Provider Directory to ensure that the location is handicap accessible prior to services. Patient restrooms should be equipped with grab bars. Handicapped parking should be available near the provider's office and clearly marked.

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A MedStar Select representative will determine compliance during the on-site office/facility review.

Provider Role in Surveys and Assessments

MedStar Select conducts a series of surveys and assessments of associates/covered dependents and providers in a continuous effort to improve performance. All providers are urged to participate when asked.

Reporting Fraud and Abuse

Reporting Fraud and Abuse to the Health Plan

MedStar Select has established a hotline that providers can use to report suspected fraud and abuse committed by any entity providing services to associates.

The hotline number is **877-811-3411** and it is available 24 hours a day, seven days a week. Voice mail is available at all times. Callers may remain anonymous and may leave a voice mail if they prefer.

Some common examples of fraud and abuse are

- Billing for services and /or medical equipment that were never provided to the associate or covered dependent
- Billing more than once for the same service
- Dispensing generic drugs and billing for brand-name drugs
- Falsifying records
- Performing and/or billing for inappropriate or unnecessary services

Suspected fraud and abuse may also be reported by mail. Please mark the outside of the envelope “confidential” or “personal” and send it to

Attn: Corporate Compliance Officer
MedStar Select
5565 Sterrett Place - 5th Floor
Columbia, MD 21044

Information reported via the website, by email or by regular mail may be done anonymously. The website contains additional information on reporting fraud and abuse.

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Provider Standards and Requirements

Provider Demographic Changes

During the time a provider is contracted with MedStar Select, the provider may have changes in office locations, tax-ID numbers, phone numbers, etc. All provider changes must be submitted in writing to the MedStar Select Provider Relations department by faxing the information to **855-600-3077** or emailing the form to the office at **MFC-ProviderDemographics@medstar.net**. Provider demographic changes must be submitted in writing directly from the provider; verbal communication will not be accepted.

Provider Relations performs site audits on all providers who open a new office location before any demographic changes are made to the provider database. Complete change requests are processed within 14 days of receipt. If Provider Relations must obtain other documents or clarification regarding the change, this will cause a delay in the processing time.

Providers should notify MedStar Select of any provider additions, practice changes or corrections within 30 days. Notification must be typewritten and submitted on business letterhead and must include the following information:

- Physician name
- Office address
- Billing address (if different than office address)
- Phone number and fax number
- Office hours
- Effective date W-9 tax form (if a tax ID change is being made)

A form to report practice changes can be found at **www.MedStarProviderNetwork.com**.

Please complete and return:
Via email: **MFC-ProviderDemographics@medstar.net**
Via fax to Provider Relations: **855-600-3077**
Via mail:

MedStar Select
Provider Relations
5233 King Ave, Suite 400
Baltimore, MD 21237

Each quarter, Provider Relations will require that providers validate the demographic information MedStar Select has on file.

Becoming a Provider

Providers interested in participating in the MedStar Select provider network should contact the Provider Relations department at **800-905-1722,** Monday through Friday, 8:30 a.m. to 5 p.m., to request an application package. Providers can also email Provider Relations at **MFC-ProviderRelations2@medstar.net**.

Once the application is received, MedStar Select will respond in accordance with Maryland or DC law as to the acceptance of the application and that the application is in process. Providers are credentialed within the timeframes established by Maryland or DC law. Providers may contact the Provider Relations department for the status on a submitted

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application. Providers will also be subject to a site audit if the office location is not currently credentialed in the network.

Provider Credentialing

MedStar Select recognizes the importance of maintaining a provider network comprised of the necessary provider types to ensure that all of the covered healthcare benefits of our associates and covered dependents are met. Our robust network of participating providers has afforded our associates and covered dependents the convenience of seeing providers who are geographically accessible. Our network providers understand, and are respectful of, health-related beliefs, cultural values and the communication styles, attitudes and behaviors of the cultures represented in the associate's and covered dependent's population.

A provider directory will be available in print form and electronically via the website. MedStar Select's Provider Relations staff will educate the provider network with regards to appointment time requirements and access to practitioners.

Initial Credentialing

All providers must be credentialed in the MedStar Select provider network before providing covered services to associates and covered dependents. Providers interested in participating in the MedStar Select provider network should contact the Provider Relations department at **800-905-1722,** Monday through Friday, 8:30 a.m. to 5 p.m., to request contracts and an application package. If providers are participating with CAQH, providers may request the MFC Provider Relations department to send them a CAQH Data Form and Attestation for completion. If providers are not participating in CAQH, they may use the paper Universal Credentialing Datasource (UCD) Application. This can be obtained on CAQH's website, **https://proview.caqh.org/Login/,** or by contacting Provider Relations. The completed CAQH data form and signed and dated attestation or full paper application must be submitted to MFC for processing. A Disclosure and Ownership Form must be completed as part of the credentialing process. Signed participation agreements must accompany the CAQH form in order for the credentialing process to begin.

MedStar Select complies with CMS and NCQA guidelines, as well as guidelines outlined by DHMH and Maryland law regarding credentialing timeframes.

The credentialing process is completed within the Maryland requirements upon receipt of all required documents. Providers may contact the Provider Relations department for a status update on the submitted application. Providers will also be subject to a site audit if the office location is not currently recognized as an approved site in the network.

Each provider who applies for participation within the MedStar Select provider network must provide documentation to satisfy the following criteria:

- A completed CAQH data form or CAQH credentialing application including a signed and dated attestation
- Completion of baccalaureate education or the equivalent and post-baccalaureate medical training from accredited schools and a subsequent internship and residency training of at least three years from ACGME accredited programs appropriate to the practice specialty, or from programs completed in the Royal College of Canada, United Kingdom, South Africa, Australia, Ireland or New Zealand.
    - Physician assistants with an associate degree from a physician assistant program will meet the education requirement.
- Current, valid, unrestricted license to practice medicine in the jurisdiction where they practice

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- Medical liability insurance coverage. Minimum liability amounts for MedStar Select are $1,000,000 per claim, $3,000,000 per aggregate.
- Current unrestricted Drug Enforcement Agency (DEA) license and an unrestricted CDS license, if applicable
- No current suspension, revocation or limitation of licensure in any jurisdiction
- No current sanctions by Medicare or Medicaid
- Current, unrestricted privileges at one of the MedStar Select participating hospitals
- Specialists must be board certified or board eligible or fall under one of the Special Cases regarding specialty credentialing (see Special Cases definitions). While individual primary care providers are not required to be board certified, MedStar Select has established a target of 80 percent board certification for its primary care panel. Allied Health Care providers must be certified in their respective specialty.
- Advanced practice nurses, under Maryland state law, are only required to have an approved attestation on file with the licensing board that the nurse practitioner has an agreement for collaboration and consulting with a licensed physician and will refer and consult with physicians and other healthcare practitioners as needed. The District of Columbia does not require a collaboration agreement with a physician.
- Participation (during credentialing or recredentialing) shall not be denied on the basis of practitioner's race, ethnic/national identity, gender, age, sexual orientation, religion, any protected category under the federal Americans with Disabilities Act or on the type of procedure or patient (e.g., Medicaid) in which the practitioner specializes. In addition, MedStar Select does not discriminate against practitioners who specialize in conditions that require costly treatments, who serve high-risk populations or who are acting within the scope of their license or certification under state law.

Recredentialing

MedStar Select, in accordance with state and federal regulatory authorities, credentialing authorities and other accrediting body (NCQA, CMS, etc.), requires recredentialing of providers every three years. If providers do not have a current and up to date CAQH record, or they do not participate with CAQH, the providers will be contacted several months prior to the actual reappointment date to begin the recredentialing process.

Provider Performance Data

Providers agree that MedStar Select may use a provider's performance data in numerous ways including but not limited to

- Recredentialing
- Pay for performance
- Quality improvement activities
- Public reporting to consumers
- Preferred status designation in the network (tiering) for narrow networks
- Reduced associate cost sharing
- Other quality activities

Provider Termination

If a provider decides that he/she no longer wishes to be a part of the MedStar Select network, the provider must submit a termination letter and allow 90 days from the time the letter is received by the Provider Relations department. All provider terminations must be submitted by fax to **855-600-3077** or via email to **MFC-ProviderRelations2@MedStar.net**.

MedStar Select will notify associates and covered dependents of any primary care provider

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terminations prior to the provider's termination date. The associate or covered dependent will be given the option of choosing a new PCP or being assigned to one. For associates and covered dependents assigned to PCP groups, they are given notice that the provider within the group has left the practice. Associates and covered dependents will remain assigned to the group unless they call Member Services to change PCPs. In some cases, associates and covered dependents who are in active treatment may be able to continue seeing the PCP for up to 90 days after the termination. The provider should contact Care Advising to discuss continuity of care issues.

For specialists that are terminating, MedStar Select will notify associates and covered dependents in active care with the provider of the provider's termination with the health plan. The associate or covered dependent will be advised to select a new specialist provider and to contact Member Services if they require assistance. In some cases, for those associates and covered dependents in active treatment, MedStar Select and the terminating provider may agree to extend the associate or covered dependent's care under the terminating provider for a period up to 90 days. The provider should contact Care Advising to discuss continuity of care issues.

On-Site Evaluation

As part of the initial credentialing and recredentialing process, the health plan will perform a site visit. The following lists some of the standards that will be assessed:

- Adequacy of waiting room and exam room space
- Availability of appointments
- Emergency care
- Hazardous waste elimination
- Medical equipment management
- Medical record documentation
- Physical accessibility, availability and appearance of practice sites
- Radiology, cardiology and laboratory services, if applicable

Provider Reimbursement

Payment is in accordance with the provider contract with MedStar Select or with the management groups that contract on the provider's behalf with MedStar Select. In accordance with the Maryland, District of Columbia and Virginia Annotated Code, Health General Article 15-1005, MSFC must mail or transmit payment to providers eligible for reimbursement for covered services within 30 days after receipt of a clean claim. If additional information is necessary, MSFC shall reimburse providers for covered services within 30 days after receipt of all reasonable and necessary documentation. MSFC shall pay interest on the amount of the clean claim that remains unpaid 30 days after the claim is filed.

Reimbursement for Maryland, District of Columbia and Virginia regulated hospitals and other applicable provider sites will be in accordance with Health Services Cost Review Commission (HSCRC) rates. Reimbursement for non-regulated hospitals in Maryland or the District of Columbia are in accordance with provider contracted agreements.

Coverage for Providers on Vacation or Leave

While on a vacation or leave of less than 30 days, a network provider must arrange for coverage by another MedStar Select health plan provider.

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Locum Tenens Billing Arrangements

Substitute providers are often necessary to cover professional practices when the regular providers are absent for reasons such as illness, pregnancy, vacation or continuing education. The regular provider should bill and receive payment for the substitute provider's services as though these services were performed by the regular provider.

The regular provider may submit the claim and receive payment in the following circumstances:

- The substitute provider does not render services to the associate or covered dependent over a continuous period of longer than 60 days.
- The regular provider identifies the services as substitute provider services by entering a Q6 modifier (services furnished by a locum tenens provider) after the procedure code.

24-Hour On-Call Coverage

PCPs and Ob-Gyns are required to provide 24-hour on-call coverage and be available seven days a week. If a provider delegates this responsibility, the covering provider must participate in MedStar Select's network and be available 24 hours a day, seven days a week.

Provider Scope of Services

Providers may bill MedStar Select for all services performed for assigned associates and covered dependents. The services should be within the scope of standard practices appropriate to the provider's license, education and board certification.

Provider Effective Date

The effective date for provider participation is the date that the MedStar Family Choice Credentialing Committee approves the application. Individual providers in the process of being credentialed should not see any MedStar Select associate or covered dependent until the credentialing process has been completed and the provider has been approved.

For Specialists: In-Office Procedures

Specialists should perform procedures only within the scope of their license, education, board certification, experience and training. MedStar Select will periodically evaluate the appropriateness and medical necessity of in-office procedures.

Guidelines Regarding Advance Directives

An advance directive is generally a written statement that an individual composes in advance of serious illness regarding medical decisions affecting him or her. The two most common forms of advance directives are a living will and a healthcare durable power of attorney.

All adults have the right to create advance directives. In the event that an individual is unable to communicate the kind of treatment he or she wants or does not want, this directive informs the provider, in advance, about that treatment.

A Living Will

A living will takes effect while the individual is still living. It is a written document concerning

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the kind of medical care a person wants or does not want if he or she is unable to make his or her own decisions about care.

A Healthcare Durable Power of Attorney
A healthcare durable power of attorney is a signed, witnessed written statement by an individual naming another person as an agent to make medical decisions if he or she is unable to do so. A healthcare durable power of attorney can include instructions about any treatment the individual desires to undergo or avoid.

Neither document becomes operative until the conditions specified in the document and relevant state law have been satisfied, such as a medical determination that the individual is unable to make decisions for himself or herself. The individual can change or revoke either document at any time. Otherwise, the documents remain effective throughout the person's life.

Accessibility Standards

MedStar Select follows accessibility requirements set forth by applicable regulatory and accrediting agencies.

Emergency Services

In case of a medical emergency, the associate or covered dependent may attempt to call his or her PCP, if possible and appropriate to the situation, explain the symptoms and provide any other information necessary to help determine appropriate action. Associates and covered dependents with an emergency medical condition should understand they have a right to summon emergency help by calling 911 or any other emergency telephone number, as well as a licensed ambulance service, without getting prior approval or attempting to call their PCP.

The associate or covered dependent should go to the nearest emergency facility for the following situations:

- If directed by the PCP
- If the associate or covered dependent cannot reach the PCP or the covering provider
- If the associate or covered dependent believes he or she has an emergency situation

MedStar Select will cover care for an emergency medical condition with symptoms of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in any of the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Urgent Care

Urgent care is defined as any illness, injury or severe condition that, under reasonable standards of medical practice, would be diagnosed and treated within a 24-hour period and, if left untreated, could rapidly become an emergency medical condition.

When in the MedStar Select primary service area, associates and covered dependents

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should contact their PCPs if they have an urgent medical need. MedStar Select encourages providers to make same day appointments available for their patients who call with unscheduled urgent healthcare needs. This improves the quality and continuity of patient care.

If associates and covered dependents are unable to contact their PCPs, and they believe they need care immediately, they should seek the medical attention they need. After such treatment, associates and covered dependents should contact their PCPs within a reasonable amount of time. A reasonable amount of time is typically considered 24 hours, unless there are extenuating circumstances.

Out-of-Area Care

Out-of-area care should not be confused with out-of-network care. Out-of-area care is care rendered to associates and covered dependents traveling or residing outside the MedStar Select plan's primary service area.

Out-of-network care is care sought by associates and covered dependents at a facility or from a provider not within the network appropriate to the associate's benefit plan.

All MedStar Select associates and covered dependents are covered for emergency care when they travel outside the MedStar Select service area.

Routine Care

Associates and covered dependents must seek routine and preventive care from providers within their network. Medical Management will review exceptions to this requirement in extenuating circumstances. Call **855-242-4875** for more information.

Injury or Illness

Those who need care while traveling outside the service area should contact his or her PCP, if applicable, within 24 hours or as soon as reasonably possible, to inform the PCP of the nature of the illness or injury. The PCP must call Medical Management at **855-242-4875** to obtain authorization for services rendered by a non-participating provider.

If Medical Management authorizes the care, the level of benefits will be determined at that time.

Associates and covered dependents who receive a bill or have paid for services provided outside the area should submit those bills to MedStar Select, using an Out-of-Network Care claim form.

An Out-of-Network Care claim form is included in the information packet, or the associate or covered dependent can download a form at **Medstarmyhealth.com**. The associate or covered dependent may also call Member Services at **855-242-4872,** Monday through Friday, 7 a.m. to 7 p.m.

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Referrals and Coordination of Care

Provider Role in Coordinating Care

The MedStar Select plan relies on each provider to ensure the appropriate use of resources by delivering quality care in the right place, at the right time. MedStar Select's approach to accountability is based on the belief that providers know what is best for associates and covered dependents. We rely on our providers to

- Provide the appropriate level of care
- Maintain high quality
- Use healthcare resources efficiently

Providers are encouraged to coordinate an associate or covered dependent's care with other specialists, therapists, hospitals, laboratories and facilities in the network appropriate to their benefit plan.

Network providers are responsible for determining the type of care the associate or covered dependent needs and the appropriate provider or facility to administer that care.

The Role of the Referring Provider

Coordination of care requires that providers communicate with specialists, therapists and other providers regarding associates' or covered dependent's care. In turn, those providers should reciprocate by informing the referring provider of their findings and proposed treatment. This sharing of information can be accomplished by telephone, fax, letter or prescription. Providers also need to supply MedStar Select with critical information needed to authorize certain types of care and process claims.

Providers should follow these steps when referring an associate or covered dependent to a specialist:

- **Direct specialty care to providers, therapists, laboratories and/or hospitals appropriate to the associate or covered dependent's benefit plan**
  The only time a provider should send an associate or covered dependent to specialists, therapists, labs and hospitals outside the associate's or covered dependent's benefit plan is when extenuating circumstances require the use of an out-of-network specialist or facility or because the only available specialist or facility is not part of their benefit plan. The provider must have prior authorization from Medical Management at **855-242-4875** to refer an associate or covered dependent to an out- of-network specialist or facility.
- **Correspond with the specialist/behavioral health provider**
  The provider may call or send a letter, fax or prescription to the specialist. The referring provider should communicate clinical information directly to the specialist without involving the member.
- **Give the facility, specialist or behavioral health provider the following referral information:**
  - Associate or covered dependent's name
  - Reason for the referral
  - All relevant medical information (e.g., medical records, test results)
  - Referring provider's name and National Provider Identifier (NPI). (This

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information is required in boxes 17 and 17A on the CMS-1500 claim form.)

- **Paper referrals are not required to be submitted with claims.**

The Role of the Specialist for MedStar Select Associates and Covered Dependents

- **Verify whether the Care was Coordinated**
  When an associate or covered dependent sees a specialist, the specialist's office needs to determine whether a provider coordinated the care or the associate or covered dependent directly accessed the specialist for care. (If care was coordinated, the PCP's name and NPI are required in boxes 17 and 17a on the CMS-1500 claim form.)

  If a provider coordinated the care, then collect any paperwork or check office records for communication from the referring doctor.

  If the associate or covered dependent self-directed care to a specialist, then contact the PCP, if applicable, to obtain medical records and check to see if any diagnostic testing has already been completed to avoid duplicate testing.

  If the associate or covered dependent does not have a PCP, then obtain a medical history and try to determine whether any prior diagnostic testing has been performed.

- **Determine the Copayment**
  If the visit is self-directed by an associate or covered dependent whose benefit plan does not require the selection of a PCP, then care is covered at a higher benefit level if the member uses a network provider and at a lower benefit level if the member uses an out-of-network provider.

  Associates and covered dependents who use in-network providers do have a copay for office visits. Cost shares may apply for other services rendered at the time of the visit.

  Associates and covered dependents who use out-of-network providers WILL have copayments, deductibles and coinsurance associated with the visit.

  Providers are required to verify benefits and authorization requirements prior to services. Provider services and authorization information is available in the "Key Contact" section of this manual.

- **Communicate Findings**
  The specialist must communicate findings and treatment plans to the referring provider within 30 days from the date of the visit. The referring provider and specialist should jointly determine how care is to proceed.

Paper referrals are not required to be submitted with claims.

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Hospital Guidelines

The MedStar Select plan urges all providers to use the services offered in an in-network hospital. This will reduce costs for MedStar Select and, more importantly, the associates and their covered dependents. This will also help ensure that associates and covered dependents receive the highest quality care.

Providers who want to use out-of-network hospitals for non-emergencies must receive prior authorization from Medical Management at **855-242-4875**. The requesting provider must give the reason for the out-of-network referral. If written information is required, it may be sent to

MedStar Select
Medical Management Department
950 N. Meridian St.
Suite 600
Indianapolis, IN 46204

Fax: 855-431-8762

Observation Status

Observation status applies to patients for whom inpatient hospital admission is being considered but is not certain. Observation status should be used when

- The associate or covered dependent's condition is expected to be evaluated and/or treated within 24 hours, with follow-up care provided on an outpatient basis.
- The associate or covered dependent's condition or diagnosis is not sufficiently clear to allow them to leave the hospital.

If an associate or covered dependent in observation status is admitted, authorization is required. Contact Medical Management at **855-242-4875** at the time of service regarding the need to admit the patient. If after hours, leave a message and a representative will follow up the next business day.

Inpatient Admissions

Network Hospitals

Network providers may admit an associate or covered dependent to any network hospital appropriate to their plan. If the admitting provider is a specialist, the specialist must communicate the admission to the associate or covered dependent's PCP to ensure continuity and quality of care.

Emergency Admission

Upon admitting an associate or covered dependent from the emergency department, the hospital should collect the following information:

- The practice name of the associate's PCP, if applicable
- The name of the associate or covered dependent's referring provider if referred for emergency care
- The name of the admitting provider if different from the referring provider or PCP

The hospital or facility must notify Medical Management at **855-242-4875** within 48 hours or on the next business day following the emergency admission.

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Elective Admission

To admit a MedStar Select health plan associate or covered dependent for an elective admission, the admitting provider must obtain prior authorization at least seven business days prior to the admission by calling Medical Management at **855-242-4875**. The admitting provider must work with the hospital to schedule the admission and any pre-admission testing.

Out-of-Network Hospitals

Emergencies

When an associate or covered dependent is admitted to an out-of-network hospital for an emergency medical condition, his or her provider should contact Medical Management at **855-242-4875** and ask to speak to a medical review nurse. The nurse may coordinate a transfer to a hospital appropriate to the associate or covered dependent's benefit plan when they are medically stable.

Non-Emergencies

Associates and covered dependents should not be admitted to out-of-network hospitals unless prior authorization is obtained for medically necessary services not available in the network. Call Medical Management at **855-242-4875** for prior authorization.

Inpatient Admission – Notification Guidelines

Inpatient Admission Notification Requirements

Notify MedStar Medicare Choice within 48 hours of hospital admission and discharges, or the next business day for weekend or holiday admissions and discharges.

Admissions to skilled nursing facility, acute rehab, or long-term acute care hospital levels of care require prior authorization.

Admission Notification **is *not*** required for the following:

- Routine labor and delivery admissions for the following federally mandated guidelines: Normal vaginal delivery w/post-partum length of stay (LOS) of 48 hours or less; Cesarean section delivery w/post-partum length of stay (LOS) of 96 hours or less. Stays beyond these guidelines will require a prior authorization for both the mother and baby.
- 23 hour outpatient surgery (exception for: Out of Network or Cosmetic procedures and E&I)
- Observation status admission for up to 23 hours

Information Needed to Report Hospital Admissions

The following data elements are necessary for accurate, efficient and timely processing of inpatient admission notification.

- Member name & ID number
- Member date of birth (DOB), address and phone number
- Admission date, if discharged provide discharge date and disposition
- Facility name & Provider NPI and TAX ID number
- Admitting physician (first & last name)
- Admitting diagnosis and/or ICD-10 code
- Admission source (emergency, elective, etc.) and admission type (medical, surgical, etc.)

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- Contact name & phone/fax number (for additional information if needed)
- Clinical Information

Submission of Hospital Admission Notifications

1. Fax of a Daily Facility Admission / Discharge Report to 703-229-6304
3. Fax of a completed inpatient Certification Request Form to 855-431-8762
4. Telephone: 855-242-4875 to report hospital admissions and/or request prior authorization.

The inpatient Certification Request Form is located on MedStar Medicare Choice website http://www.medstarprovidernetwork.com/>Provider Resources (Including Medical Authorization Forms) >Medical Authorization Forms> Certification Request for Authorization of Services.

If the above information is not received timely this may result in a delay of decision making and subsequent determination. As these cases will be sent to the Medical Director for review and determination. More information on the determination process can be found in the Provider Appeals section of this manual.

Inpatient Consultation and Referral Process

If the admitting provider determines that an associate or covered dependent requires a consultation with a specialist, the admitting provider must refer that associate or covered dependent to a network specialist appropriate to the benefit plan if a network specialist is available. The referral should follow the hospital's locally approved procedures (e.g., consultation form, physician order form).

The admitting provider and specialist jointly should determine how care should proceed. Coordination of care occurs through active communication among the PCP, the admitting provider and the specialist.

Pre-Admission Diagnostic Testing

All pre-admission diagnostic testing conducted before an associate or covered dependent's medically necessary surgery or admission to the hospital is covered when performed at a hospital appropriate to the associate or covered dependent's benefit plan. Some procedures may require prior authorization.

Transfers

Transfers between Network Facilities

If an associate or covered dependent is admitted to a network hospital and needs to be transferred to another hospital, the MedStar Select health plan requires that they be sent to a hospital appropriate to the associate or covered dependent's benefit plan. The transferring provider must coordinate the transfer with a representative at the receiving facility. Providers must contact Medical Management at **855-242-4875** to arrange any type of transportation.

All transfer procedures and reimbursement will be rendered in accordance with applicable Maryland or District of Columbia State Laws, based on the associate or covered dependent's location.

Transfers to Out-of-Network Facilities

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MedStar Select requires prior authorization for transfer to an out-of-network facility. The transferring provider must contact Medical Management at **855-242-4875** and speak to a medical review nurse. Without prior approval, coverage will be denied.

Discharges

Medical Management works with the hospital's Utilization Management department to coordinate discharge planning. A discharge planner is available to assist in coordinating follow-up care, ancillary services and other appropriate services. Contact Medical Management at **855-242-4875** to speak to a discharge planner.

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Provider Appeals

Right to Appeal

Healthcare providers have the right to appeal MedStar Select's decision to deny benefit coverage for healthcare services. Appeals fall into three categories: medical necessity, expedited and administrative. The request for an appeal should be mailed to

MedStar Select – Provider Appeals
P.O. Box 269
Pittsburgh, PA 15230-0269

NOTE: The resubmission of a corrected claim due to a minor error or omission is not an appeal. Corrections or resubmissions of claims due to minor errors or omissions should be sent to the customary claim address. A Claim Reconsideration Form can be found in the "Forms" section on **MedStarProviderNetwork.com**.

Medical Necessity Appeals

Medical necessity appeals must be submitted in writing within 180 days from the date of the notice of denial. The medical necessity appeal request should include the reason for the appeal, a clear statement of why and on what basis the provider wishes to appeal, as well as a copy of the medical record or other supporting documentation. We encourage the use of the Claims Appeal Form located in the "Forms" section on **MedStarProviderNetwork.com.** A physician who was not involved with the initial determination will review the appeal. The physician will determine if additional information has been presented that supports a reversal of the denial.

Expedited Appeal

A provider can request an expedited review if a provider with knowledge of the associate or covered dependent's medical condition believes an associate or covered dependent's life, health or ability to regain maximum function is in jeopardy because of the time required for the usual review process.

A decision is rendered as quickly as is warranted by the associate or covered dependent's condition but no later than 72 hours after the review is received.

An expedited review can be requested by calling Medical Management at **855-242-4875**. Clinical documentation is required.

Administrative Appeal

An administrative appeal is an appeal that involves claims that have been denied for reasons other than those related to medical necessity. Examples include

- Care not coordinated with a PCP
- Prior authorization not obtained

Administrative appeals must be submitted in writing within 120 days from the date of the notice. All decisions are final. We encourage the use of the Claims Appeal Form located in the "Forms" section on **MedStarProviderNetwork.com.**

If you have questions about the right to appeal or the procedure to file an appeal, or wish to request a hard copy of this information, please contact Provider Services at **855-222-1042**.

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Provider Sanctioning

MedStar Select Health Plan follows a three-phase process for addressing the actions of providers who fail to follow the policies and procedures of the health plan.

Actions That Could Lead to Sanctioning

Actions that could lead to sanctioning fall into three main categories: administrative non-compliance, unacceptable resource utilization and quality of care concerns.

- **Administrative Noncompliance**
  Administrative noncompliance is consistent or significant behavior that is detrimental to the success or functioning of MedStar Select. Examples include
  - Conduct that is unprofessional or erodes the confidence of MedStar Select associates and covered dependents
  - Direct or balance billing for services

- **Unacceptable Resource Utilization**
  Unacceptable resource utilization is a utilization pattern that deviates from acceptable medical standards and may adversely affect the quality of care offered.

- **Quality of Care**
  A quality of care issue may arise from an episode that adversely affects the functional status of an associate or covered dependent or a pattern of medical practice that deviates from acceptable medical standards.

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