Provider Standards & Procedures

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Provider Rights, Responsibilities and Roles

Provider Rights

Providers have a right to

- Be treated by their members and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for members' care
- Have their members act in a way that supports the care given to other members and that helps keep the doctor's office, hospital or other offices running smoothly
- Expect other network providers to act as partners in members' treatment plans
- Expect members to follow their directions, such as taking the right amount of medication at the right times
- Help members make decisions about their treatment, including the right to recommend new or experimental treatments
- Make a complaint or file an appeal against MedStar Medicare Choice Health Plan (Medicare Choice) and/or a member
- Receive copayments, coinsurance and deductibles as appropriate
- File a grievance with Medicare Choice on behalf of a member and with the member's consent
- Have access to information about the Medicare Choice's Quality Improvement programs, including program goals, processes and outcomes that relate to member 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 member care and services

Provider Responsibilities

Providers have a responsibility to

- Treat members with fairness, dignity and respect
- Not discriminate against members 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 members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give member's a notice that clearly explains their privacy rights and responsibilities as they relate to the provider's practice/office/facility
- Provide member's with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow members to request restriction on the use and disclosure of their personal health information
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records

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

Provider Role in Compliance

Medicare Choice 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, Medicare Choice established its distinct Compliance program.

The Medicare Choice 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, members 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 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).

The Medicare Choice director of Medicare compliance may also be contacted directly at **202-243-5419**.

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.
- Medicare Choice 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.
- Medicare Choice prohibits retaliation against providers or any affiliates who participate in an investigation or provide information relating to an alleged violation.

The success of Medicare Choice'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 Medicare Choice's Compliance program and/or a contracted provider's responsibilities, please call the Health Integrity Hotline at **877-811-3411** or the Medicare Choice Director of Medicare Compliance at **202-243-5419.**

CMS Provider Fraud Waste and Abuse and General Compliance Training Requirements

CMS requires sponsors to provide general compliance and FWA training to all First-Tier, Downstream and Related Entities (FDRs) that are contracted with the sponsor to provide benefits or services. Providers who participate in Medicare Choice are considered first-tier entities, as they have a contractual relationship with MedStar Health to deliver healthcare services to Medicare members.

All providers delivering services to Medicare members must complete required training upon initial contract and at least annually thereafter. As of January 1, 2016, all required training is located on the Medicare Learning Network (MLN):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

We recognize that healthcare providers enrolled in the Medicare program or accredited as a durable medical equipment prosthetics, orthotics and supplies (DMEPOS) provider are deemed to have met the FWA training and education requirements. You must submit an attestation to MedStar via fax or email to prove that your organization is deemed for the FWA requirement. Deemed individuals are still required to complete the general compliance training.

Please send attestation to:
Fax: 855-600-3077
Email: MFC-ProviderRelations2@medstar.net

If you do not fulfill this requirement, you will be out of compliance with CMS and MedStar requirements, which may result in the termination of your agreement or contract.

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

Medicare Choice 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 Medicare Choice staff.

Medicare Choice has incorporated measures in all of its departments to make sure potential, current and former members' 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. Medicare Choice members may use and disclose this information only for those purposes permitted by federal law or regulation (for treatment, payment and healthcare operations); by the member'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 Medicare Choice's Member Services department and the Medicare Choice website. This form complies with the core elements and statements required by HIPAA privacy rules. This form must be completed, signed and returned to Medicare Choice before it will release information.

All members receive MedStar Health's Privacy Statement and Notice of Privacy Practices in their welcome kit materials. Members receive a copy of this privacy information annually. These documents clearly explain the members' 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 members of MedStar Health's precautions to conceal individual health information from employers.

MedStar Health's Notice of Privacy Practices is separate and distinct from the Notice of Privacy Practices providers are required to give to their members under HIPAA. The Medicare Choice 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.

Medicare Choice 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 the location is handicap accessible prior to services. Member restrooms should be equipped with grab bars. Handicapped parking should be available near the provider's office and clearly marked.

A Medicare Choice representative will determine compliance during the on-site office/facility review.

Provider Role in Surveys and Assessments

Medicare Choice conducts a series of surveys and assessments of members 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 Medicare Choice has established a hotline that providers can use to report suspected fraud and abuse committed by any entity providing services to members.

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.

The Medicare Choice Director of Medicare Compliance may also be contacted directly at **202-243-5419**.

Some common examples of fraud and abuse are

- Billing for services and /or medical equipment that were never provided to the member

- 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 Medicare Choice
5233 King Ave
Suite 400
Baltimore, MD 21237

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

Reporting Fraud and Abuse to CMS

The Centers for Medicare and Medicaid Services (CMS) has established a hotline to report suspected fraud and abuse committed by any person or entity providing services to Medicare beneficiaries.

The **hotline** number is **800-HHS-TIPS (800-447-8477)**, and it is available Monday through Friday from 8:30 a.m. to 3:30 p.m. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Provider Standards and Requirements

Becoming a Provider

Providers interested in participating in the MedStar Medicare Choice 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 Medicare Choice will respond in accordance with laws, applicable to the service area, as to the acceptance of the application and that the application is in process. Providers are credentialed within the time frames established by laws within the service area. Providers may contact the Provider Relations department for the status on a submitted application. Providers will also be subject to a site audit if the office location is not currently credentialed in the network.

Provider Credentialing

Medicare Choice 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 members our met. Our robust network of participating providers has afforded our members 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 member population.

A provider directory will be available in print form and electronically via the website. MedStar Medicare Choice'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 Medicare Choice network before providing covered services to Medicare Choice members. Providers interested in participating in the Medicare Choice 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 Medicare Choice 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 Medicare Choice 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.

Medicare Choice complies with CMS and NCQA guidelines, as well as guidelines outlined by DHMH and Maryland law regarding credentialing time frames.

The credentialing process is completed within the Maryland requirements upon receipt of all required documents. Providers may contact the Provider Relations department for the status 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 Medicare Choice 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
- Medical liability insurance coverage. Minimum liability amounts for Medicare Choice are $1,000,000 per claim, $3,000,000 per aggregate.
- A history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the healthcare professional
- Current, adequate malpractice insurance meeting MedStar's requirements
- 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 Medicare Choice participating hospitals
- Eligibility for participation in Medicare (did not opt-out)
- 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, Medicare Choice has established a target of 80 percent board certification for its primary care panel. Allied healthcare 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 or any protected category under the federal Americans with Disabilities Act, or on the type of procedure or member (e.g., Medicaid) in which the practitioner specializes. In addition, Medicare Choice 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

Medicare Choice, 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.

On-Site Evaluation

As part of the initial credentialing and re-credentialing 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 Information Changes

During the time a provider is contracted with Medicare Choice, the provider may have changes in office locations, tax-ID numbers, phone numbers, etc. All provider changes must be submitted to the Medicare Choice Provider Relations department by faxing the information to **855-600-3077** or emailing the form to **MFC-ProviderDemographics@medstar.net**.

Provider Relations performs site audits on all providers who open a new office location before any demographic changes are made to the provider's individual and group record in the credentialing database. Members should not be seen in the new location until the site visit has been performed. 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.

Each quarter, Provider Relations will require that you validate the demographic data we have on file.

Providers should notify MedStar Medicare Choice 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

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 Medicare Choice Health Plan Provider Relations
5233 King Avenue
Suite 400
Baltimore, MD 21237

Provider Termination

If a provider decides that he/she no longer wishes to be part of the Medicare Choice 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 by email to **MFC-ProviderRelations2@medstar.net**.

Medicare Choice will notify members of any primary care provider terminations prior to the provider's termination date. The members will be given the option of choosing a new PCP or being assigned to one. For members assigned to PCP groups, they are given notice that the provider within the group has left the practice. Members will remain assigned to the group unless he/she calls Member Services to change PCPs. In some cases, members 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 Management to discuss continuity of care issues.

For specialists that are terminating, Medicare Choice will notify members in active care with the provider of the provider's termination with the Health Plan. The member will be advised to select a new specialist provider and to contact Member Services if they require assistance. In some cases, for those members in active treatment, Medicare Choice and the terminating provider may agree to extend the member's care under the terminating provider for a period up to 90 days. The provider should contact Care Management to discuss continuity of care issues.

Provider Reimbursement

Payment is in accordance with the provider contract with Medicare Choice or with the management groups that contract on the provider's behalf with Medicare Choice. In accordance with the Maryland or the District of Columbia Annotated Code, Medicare Choice 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, Medicare Choice shall reimburse providers for covered services within 30 days after receipt of all reasonable and necessary documentation. Medicare Choice shall pay interest on the amount of the clean claim that remains unpaid 30 days after the claim is filed.

Reimbursement for Maryland 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.

Provider Performance Data

Medicare Choice 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 member cost sharing
- Other quality activities

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 Medicare Choice provider.

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 members 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

Providers 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 the Health Plan's network and be available 24 hours a day, seven days a week.

Provider Scope of Services

Providers may bill Medicare Choice for all services performed for assigned members. 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 Medicare Choice members until the credentialing process is complete 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. Medicare Choice 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 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

The Health Plan follows accessibility requirements set forth by applicable regulatory and accrediting agencies.

Emergency Services

In case of a medical emergency, members may attempt to call his or her PCP, if possible, to explain the symptoms and provide any other information necessary to help determine appropriate action.

The members should go to the nearest emergency facility for the following situations:

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

Members 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.

Medicare Choice 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 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 Medicare Choice primary service area, members should contact their PCPs if they have an urgent medical need. Medicare Choice encourages providers to make same day appointments available for their members who call with unscheduled urgent healthcare needs. This improves the quality and continuity of member care.

If members are unable to contact their PCPs, and they believe they need care immediately, they should seek the medical attention they need. After such treatment, members 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 members traveling or residing outside the MedStar Medicare Choice plan's primary service area.

Out-of-network care is care sought by members at a facility or from a provider not within the network appropriate to the member's benefit plan.

All MedStar Medicare Choice members are only covered for emergency care when they travel outside the MedStar Medicare Choice service area.

Routine Care

Members must seek routine and preventive care from providers within their network. Medical Management will review in extenuating circumstances. Call **855-242-4875** for more information.

Injury or Illness

A member who needs 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.

Members who receive a bill or have paid for services provided outside the area should contact Member Services at **855-222-1041.**

Referrals and Coordination of Care

Provider Role in Coordinating Care

Medicare Choice relies on each provider to ensure the appropriate use of resources by delivering quality care in the right place, at the right time. Medicare Choice's approach to accountability is based on the belief that providers know what is best for members. We rely on our providers to

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

Providers are encouraged to coordinate a member's care with other specialists, therapists, hospitals, laboratories and facilities in the network appropriate to the member's benefit plan.

Network providers are responsible for determining the type of care the member 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 members' 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 the MedStar Medicare Choice plan with critical information needed to authorize certain types of care and process claims.

Providers should follow these steps when referring a member to a specialist:

- **Direct specialty care to providers, therapists, laboratories and/or hospitals appropriate to the member's benefit plan**
  The only time a provider should send a member to specialists, therapists, labs and hospitals outside the member'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 the member's benefit plan. The provider must have prior authorization from Medical Management at **855-242-4875** to refer a member 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:**
  - Member'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 information is required in boxes 17 and 17A on the CMS-1500 claim form.)

Please note, paper referrals are not required to be submitted with claims.

The Role of the Specialist for MedStar Medicare Choice Members

- **Verify whether the care was coordinated**
  When a member sees a specialist, the specialist's office needs to determine whether a provider coordinated the care or the member 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 member 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 member does not have a PCP, then obtain a medical history and try to determine whether any prior diagnostic testing has been performed.

  Do not turn a patient away if they present without a referral. A referral is not required for claim payment.

- **Determine the copayment**
  If the visit is self-directed by a member 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.

  Members who use in-network providers may have coinsurance or copayments for office visits. Cost shares may apply for other services rendered at the time of the visit.

  Members must have an authorization to see an out-of-network provider prior to the visit and cost shares will apply.

  Providers are required to verify members' benefits and authorization requirements prior to services.

- **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.

Please note, paper referrals are not required to be submitted with claims.

Hospital Guidelines

The MedStar Medicare Choice plan urges all providers to use the services of a network hospital. This will reduce costs for Medicare Choice and, more importantly, the members. This will also help ensure that members 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 Medicare Choice
Medical Management Department
One Chatham Center
112 Washington Place
Pittsburgh, PA 15219
Fax: 855-431-8762

Observation Status

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

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

If a member 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 a member to any network hospital appropriate to the member's benefit plan. If the admitting provider is a specialist, the specialist must communicate the admission to the member's PCP to ensure continuity and quality of care.

Emergency Admission

Upon admitting a member from the emergency department, the hospital should collect the following information:

- The practice name of the member's PCP, if applicable
- The name of the member'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.

Elective Admission

To admit a Medicare Choice member 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 a member is admitted to an out-of-network hospital for an emergency medical condition, the member's 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 member's benefit plan when the member is medically stable.

Non-Emergencies

Members 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 Consultation and Referral Process

If the admitting provider determines that a member requires consultation with a specialist, the provider must refer the member to a network specialist appropriate to the member's benefit plan, if one 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 a member's medically necessary surgery or admission to the hospital is covered when performed at a hospital appropriate to the member's benefit plan. Some procedures may require prior authorization.

Transfers

Transfers between Network Facilities

If a member is admitted to a network hospital and needs to be transferred to another hospital, Medicare Choice requires that the member be sent to a hospital appropriate to the member'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 member's location.

Transfers to Out-of-Network Facilities

MedStar Medicare Choice 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.

Provider Appeals

Right to Appeal

Healthcare providers have the right to appeal Medicare Choice'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 Medicare Choice – 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 is available in the "Forms" section on **www.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 available in the "Forms" section on www.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 member's medical condition believes a member'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 member'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 available in the "Forms" section on **www.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 your network management representative or call Provider Services at **855-222-1042**.

Provider Sanctioning

Medicare Choice 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 the Health Plan. Examples include:

- Conduct that is unprofessional or erodes the confidence of health plan members
- 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 a member's quality of care.

Quality of Care

A quality of care issue may arise from an episode that adversely affects the functional status of a member or a pattern of medical practice that deviates from acceptable medical standards.