

# MedStar Select Provider Newsletter

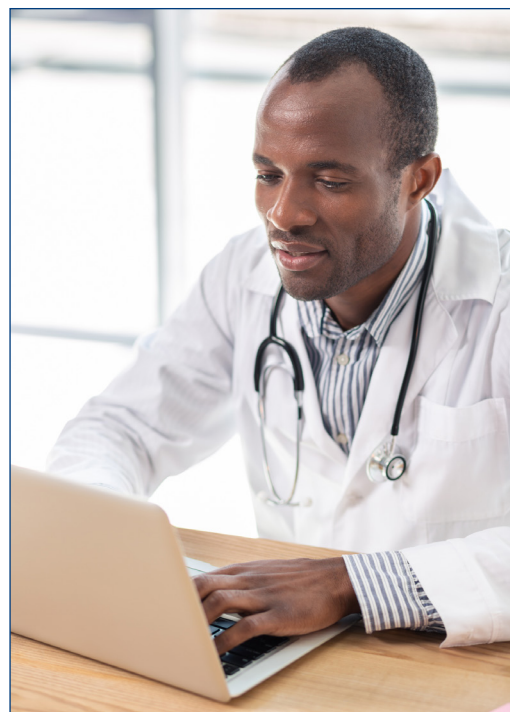
## Provider Credentialing and Recredentialing

Accurate and timely provider data is essential to keeping MedStar Select's credentialing system running smoothly. MedStar Select's credentialing system helps to develop directories, and assists with paying claims. Collecting and maintaining accurate provider data can be challenging which is why we rely on providers to keep their CAQH online application up to date. In addition, MedStar Family Choice providers are required to comply with the following:

- Providers shall immediately notify MedStar Select of any changes in the status of licensure (i.e., suspended, revoked, surrendered, new licensure number, etc.).
- Providers shall maintain a valid and current license to practice at all times.
- DEA or CDS Certificates applies to providers who are qualified to write prescriptions, and providers must also maintain a valid and current certificate at all times.
- Every 120 days practitioners must re-attest that their CAQH online application is correct.
- Providers will notify MedStar Select of the suspension, loss or reduction of hospital privileges.

### CAQH Benefits to Providers

- Free service to providers
- Easy to use
- Enter, submit, and store all data electronically
- Eliminates the need for time-consuming paper forms
- Enhanced security features help you maintain total control of your information
- Re-attest in minutes
- Updated information is immediately available to organizations authorized by the provider
- Upload supporting documents directly into CAQH ProView to eliminate the need for manual submission, and to improve the timeliness of completed applications



# MedStar Select Annual Enrollment

The annual enrollment period for MedStar Select will begin on Oct. 29 and run through Nov. 18, for benefits beginning on Jan. 1, 2020. The MedStar Select Plan offers comprehensive medical coverage for MedStar Health associates and their dependents through the MedStar Select Provider Network. This network consists of not only MedStar-employed providers, but also a full complement of contracted community providers. The plan offers in-network and out-of-network benefits. We recommend you select a primary care physician (PCP) to coordinate your care. Referrals are not necessary for specialty care.



For more information, or to confirm if you are in the MedStar Select Provider Network, visit [MedStarMyHealth.org](http://MedStarMyHealth.org) or call **855-242-4872**.

## Welcome New Providers to MedStar Select

MedStar Health would like to welcome the following new providers to our network!

- **Asima Rahman LLC**  
(Internal Medicine, Baltimore, Baltimore County)
- **Audiology Center of Maryland Inc.**  
(Audiology, Germantown, Montgomery County)
- **MedStar Medical Group Surgical Specialties**  
(Hematology Oncology, Olney, Montgomery County)

In addition, we welcome the following ancillary provider groups into the network:

- Skilled nursing facilities: **Collingswood Rehabilitation and Healthcare Center, Crescent Cities Nursing and Rehabilitation Center, Elkton Nursing and Rehabilitation Center, and Potomac Valley Rehabilitation and Healthcare Center**
- Durable medical equipment companies: **American Homecare Equipment Inc, Medic-Aire Medical Equipment, NeighborCare Home Medical Equipment of Maryland LLC, and Trustcare Home Medical Equipment Inc**
- Ambulatory Surgical Center: **MedStar Surgery Center at Takoma Park**
- Sleep Center: **REM Sleep Diagnostics LLC**



# MedStar Select Pharmacy Benefits

MedStar Select members are covered under a prescription benefit plan administered by CVS/Caremark. As a way to help manage healthcare costs, authorize generic substitution whenever possible. Consider prescribing a brand name on the preferred drug list at **MedStarProviderNetwork.org** if you believe a brand name product is necessary.

Please note:

- Generics should be considered the first line of prescribing.
- The drug list represents a summary of prescription coverage; it is not inclusive and does not guarantee coverage.
- The member's prescription benefit plan may have different copay for specific products on the list.
- Unless specifically indicated, drug list products will include all dosage forms.
- Log in to **Caremark.com** to check coverage and copay information for a specific medicine.
- For drugs covered under the medical benefit that require prior authorization, please refer to **855-266-0712**. An example would be drugs administered in the office would be covered under the medical benefit. Patients are not picking up the prescription at the pharmacy. Please reference the prior authorization list on **MedStarProviderNetwork.org**.

## Where can MedStar Select Members get their Vaccines?

Any in-network pharmacy can administer and bill for both the cost of the drug and the administration of the drug through the member's pharmacy benefit. Some vaccines can also be administered in the provider office. Please visit **MedStarProviderNetwork.org** for a listing of covered vaccines and where they can be administered. The following seasonal and nonseasonal vaccines are available to MedStar Select members at no additional cost at any participating in-network pharmacy.

### Seasonal Vaccines:

- Injectable Flu vaccine (Trivalent and Quadrivalent)
- Injectable High-Dose vaccine
- Intranasal Flu vaccine

### Nonseasonal Vaccines:

- Pneumonia
- Diphtheria
- Zoster (Zostavax®)
- Tetanus
- Diphtheria Toxoids
- Pertussis
- Hepatitis A
- Hepatitis B
- Haemophilus B
- Human Papillomavirus (Gardasil®)
- Meningococcal
- Varicella
- Inactivated Poliovirus
- Measles
- Mumps
- Rubella
- Rotavirus
- Meningococcal
- Varicella

# Documentation and Coding Audits

Throughout each year, we conduct focused and routine chart audits. If a provider's office is selected for review, we will contact the physician's office and request copies of the medical records for specific dates of services for our members. The records are reviewed by our compliance analyst and each code that was billed and paid is analyzed. Many of our reviews focus on E/M visits. Providers should ensure that the medical record documentation supports the level of service billed, coding, and documentation requirements for time-based procedures are met, and the services performed meet medical necessity. Medical necessity of a service is determined through various factors, including, but not limited to:

- Clinical judgment
- Standards of practice

## Chief complaint

- Any acute exacerbations or onsets of medical conditions or injuries
- The acuity of the patient
- Multiple medical co-morbidities
- The management of the patient for that specific date of service. The volume of documentation should not be the primary influence upon which a specific level of service is billed.

To avoid payment retractions, the documentation in the medical records must be legible, dated, signed by the provider, and support the CPT code that was billed on the claim. If you have any questions regarding chart audits, please contact Provider Relations at **800-905-1722, option 5**.

## Refunds

If MedStar Select has paid in error, providers may return the check or write a separate check from their account for the full amount paid in error. Providers should include a copy of the remittance advice, supporting documentation noting the reason for the refund and the explanation of benefits (EOB) from other insurance carriers, if applicable. Refunds should be sent directly to the General Accounting department at this address:

Attn: General Accounting  
MedStar Select  
24th Floor  
600 Grant St.  
Pittsburgh, PA 15219

## Overpayment

If MedStar Select has paid in error and the provider has not sent a refund or returned the check, money will be deducted from future claims paid. The related claim information will be shown on the remittance advice as a negative amount. Providers will be notified of overpayment and/or retraction of funds. Providers are required to report overpayments to MedStar Select if errors are identified prior to receiving plan notification.

## Verification of High Dollar Claims

MedStar Select has a process to review high dollar claims prior to payment to verify accuracy of reimbursement. A high dollar claim is defined as any claim with a total payment amount that is determined to be equal to or greater than \$25,000. Once claims are received via electronic or paper format, those exceeding the dollar threshold amount are held for the Quality Assurance department to complete a comprehensive review prior to payment distribution.

Within two (2) business days of receipt, the representative from the Quality Assurance department reviews the high dollar claim for accuracy. After the claim is reviewed, remarks are added stating if corrections to the claim are required prior to the claim being released. If the claim is correct, it is routed back to the Claims department to be released if the total payment amount is less than \$100,000.

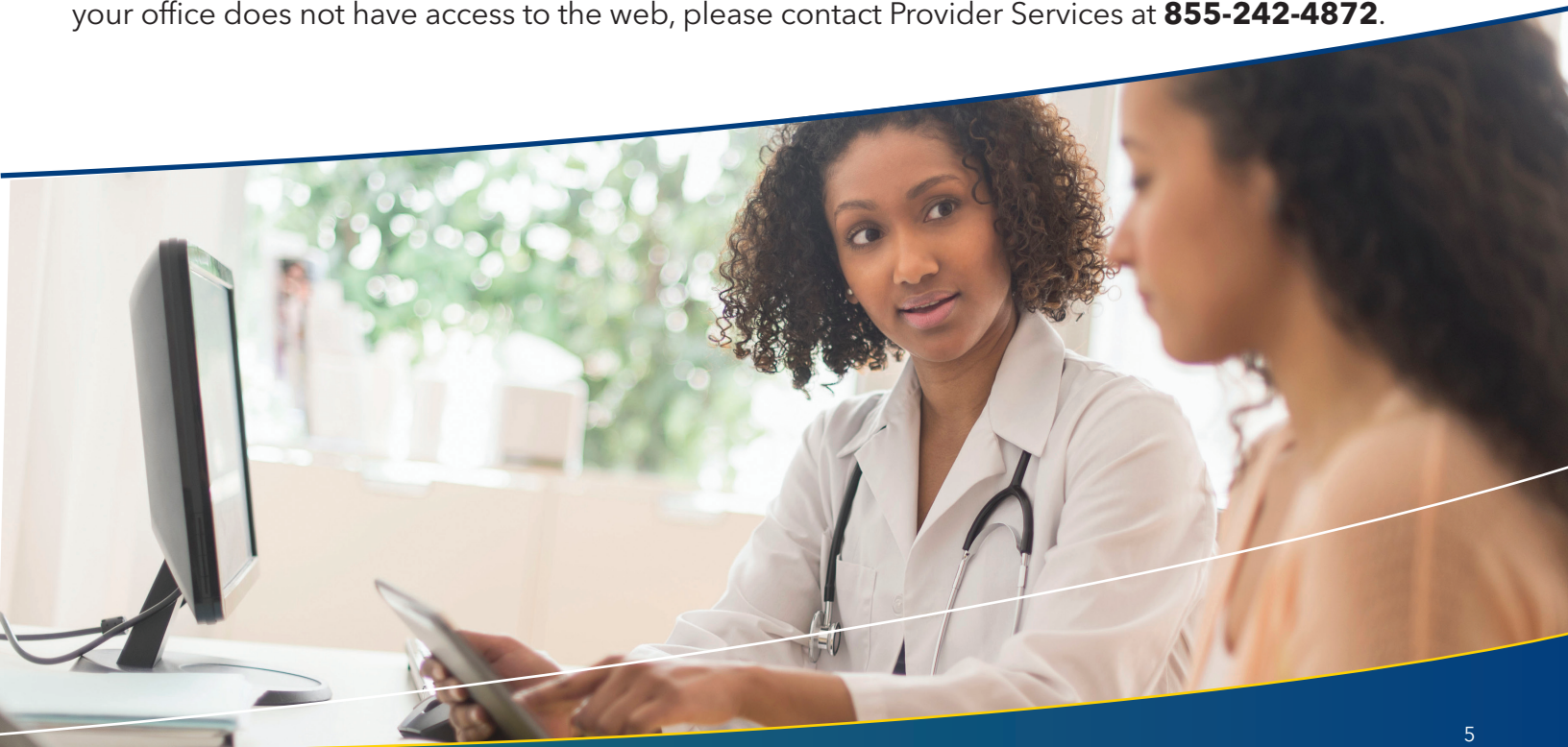
Claims \$100,000 or greater are routed back to the Claims department to be released by a manager. If corrections are needed, it is routed back to the Claims department for corrections prior to release. A small subset of claims also undergo a coding and/or clinical review. The claims forwarded for review include (but are not limited to) when the allowed amount exceeds the billed amount on the claim; or when pharmacy or supply charges seem unusually high.

These reviews could result in a request for medical records to support the services billed, which must be received in order to approve payment. Three outreach attempts will be made. If the information is not received after three attempts, the claim could be denied. Audits are performed on a sample of claims on both a weekly and monthly basis to validate that high dollar claim reviews are being performed accurately and appropriately. For more information on the high dollar claim review process, please contact Provider Services at **855-222-1042**.

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## Find a Provider - Online Directory

Finding a participating MedStar Select provider couldn't be easier! Visit **MedStarProviderNetwork.org** to look up participating PCPs and specialists by logging on to our online provider directory. Providers can be found by completing one or more of the search fields to get updated information instantly. If your office does not have access to the web, please contact Provider Services at **855-242-4872**.



## MedStar Select Provider Appeals Address

Please make sure to submit all provider appeals in writing to the correct address for MedStar Select. The correct address is listed below. Provider appeals sent to the incorrect address could result in the appeal not being received by MedStar Select, or could delay processing.

MedStar Provider Appeals  
PO Box 269  
Pittsburgh, PA 15230  
Fax: **855-435-8762**

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## Let's Decrease Emergency Room Utilization As A Team

MedStar Health is looking to reduce emergency room (ER) utilization for minor illnesses or injuries. As providers, you can have a meaningful impact on accomplishing this goal. When you see a MedStar Select member, please discuss with them that there are other options to being treated for minor illnesses or injuries.

- Encourage the member to contact you or your office first before going to the ER unless it is life threatening.
- If your office provides extended office hours or urgent care services, please educate our members about this available option and explain the benefits of not sitting in the ER.
- Encourage the use of an urgent care facility when appropriate like MedStar PromptCare, Patient First, Express Care or Righttime Medical Care. Explain to the member that it's more convenient because of the decreased wait time.
- Help us educate our members of the availability of MedStar eVisit. MedStar Select members have free 24/7 video access to trusted medical providers from their tablet, smartphone, or computer through MedStar eVisit.

Thank you for partnering with us in educating our members on appropriate use of the ER.



# Care Advising: Helping You Care for High-Risk Patients at \$0 Cost

Care advising offers personalized, one-on-one support to your patients who need extra help managing their health. Care advising uses evidence-based programs and proactive care delivery to help improve patient outcomes and reduce costs.

Informed by the patient's primary care team, care advising serves as a complement of care outside of the office setting. Care advisors, who are registered nurses, work with patients across a continuum of care management programs, including:

- Transition care, which focuses on patients who are at high risk for hospital readmissions
- Complex care, which focuses on patients likely to incur a disease-specific admission

## What Care Advisors Do:

- Help patients identify their personal health goals and create a care plan to achieve those goals
- Work closely with you to review your patient's care plan and monitor progress
- Regularly check on patients' progress, care plan adherence, and assess ongoing needs
- Help patients get doctor visits and screenings scheduled
- Attend doctor visits where appropriate
- Find appropriate support services close to patients' home or work
- Help with medication questions, food choices and social needs

Working on behalf of MedStar Health and the patient's primary care doctor, care advisors will engage eligible patients by phone or in person. Patients who choose to participate will work with the same care advisors until their goals are achieved, which gives the care advisors greater opportunity to get to know each patient's unique healthcare needs.

At this time, MedStar employees and their dependents covered by MedStar Select may be eligible for care advising services. Only those individuals who are identified as in need of additional support—through physician referral and a comprehensive assessment of health data—will be contacted to participate. If you believe you have a patient who may be appropriate for care advising services, contact our care advising line: **888-959-4033**.

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## Pass-Through Billing

MedStar Select and the Maryland Department of Health prohibit pass-through billing. Pass-through billing occurs when the ordering provider requests and bills for a service, but the service is not performed by the ordering provider or those under their direct employ. If you are a physician, practitioner, or medical group, you must only bill for services that you or your staff perform. The performing provider should bill for these services unless otherwise approved by MedStar Select.

## MedStar Select Policy Updates

A new policy related to Platelet Rich Plasma will be implemented on October 1, 2019 for MedStar Select. With this update, procedure codes 0489T, 0490T, S9055, 0481T and 86999 will no longer be covered and will deny as experimental and investigational. Procedure codes 0232T, G0460 and P9020 which are also included in the policy currently deny as experimental and investigational and will continue to do so. For additional information, please refer to the policy located on **MedStarProviderNetwork.org** under the section titled "Medical Polices Requiring Prior Authorization."

An update to the HPV Vaccine Policy went into effect with a retro effective date of January 1, 2019 to expand the covered age range for Gardasil 9 (Procedure Code 90651) from ages 9 through 26 to ages 9 through 45. For additional information, please refer to the policy located on **MedStarProviderNetwork.org** under the section titled "Medical Payment Policies."

For questions or concerns regarding the new policies, please contact the Medical Management / Prior Authorization Department at **800-242-4875**.

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## Contact Us

We are here to help. Please reference the below list of numbers if you have any questions or concerns.

### Member Services

**855-242-4872 PHONE**

Monday through Friday, 7 a.m. to 7 p.m.

### Care Management

**888-959-4033 PHONE**

Monday through Friday, 8:30 a.m. to 5 p.m.

### Medical Management/Prior Authorization

**855-242-4875 PHONE**

Monday through Friday, 8:30 a.m. to 5 p.m.

### Provider Services

(For claims and eligibility inquiries)

**855-222-1042 PHONE**

Monday through Friday, 8:30 a.m. to 5 p.m.

### Provider Relations

(For credentialing/re-credentialing or practice additions/terminations/address changes)

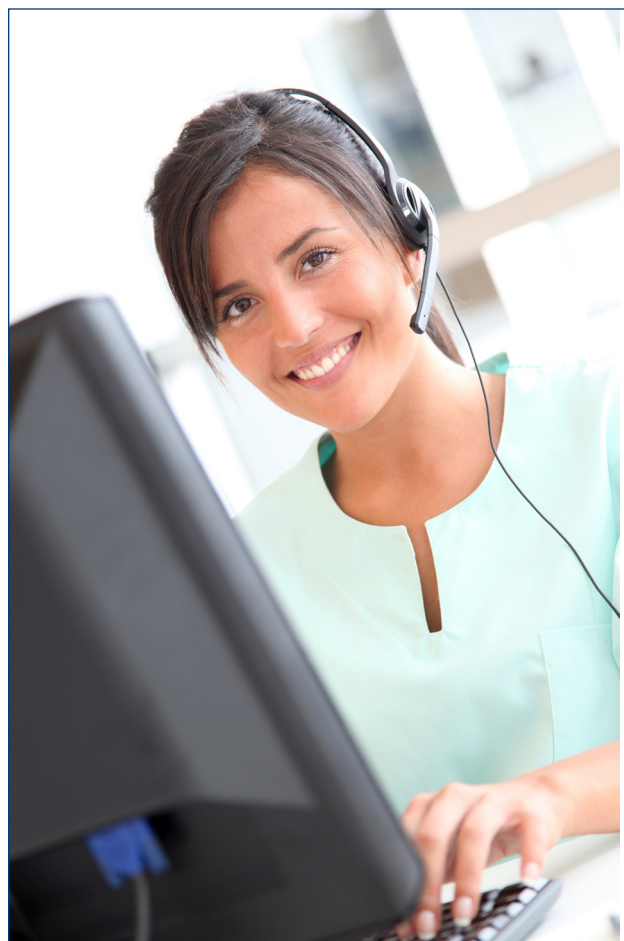
**800-905-1722, option 5 PHONE**

Monday through Friday, 8:30 a.m. to 5 p.m.

### Interactive Voice Recognition

**855-275-1251 PHONE**

To verify member eligibility, access the provider website at **MedStarProviderNetwork.org** or call Provider Services at **855-222-1042**.





## Effective Communication

Many patients have little experience with medical terminology and keeping it simple makes things easier for the patient to understand. Patients who understand the information their practitioners are presenting to them about their health and treatment are more likely to follow instructions to improve their health.

To communicate effectively with patients, practitioners need to be mindful that each patient is different, so their communication techniques must be diverse as well. Providers should realize that all patients are unique, and keeping up to date with various backgrounds, cultures, social and economic issues, past history, etc., could potentially help providers better communicate with their patients on an individual level.

Encouraging patient involvement is also a great tool to bridge the communication gap between providers and patients. Providers must recognize when to call upon the help of the patient's family and friends (with the patient's permission, of course) to assist with communication and cultural differences when needed. Some educational resources include: Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) training, CME, specialty education, and CLAS modules. More resources can be found on the U.S. Department of Health & Human Services Think Cultural Health website at **ThinkCulturalHealth.HHS.gov**. For language barriers, providers should utilize interpretation services, as they are available.

MedStar Select members can call Member Services at **855-242-4872** to address any benefit questions. MedStar Select members may also visit **MedStarMyHealth.org** for any additional questions.

Taking all of these steps will help to foster a good relationship between you and your patients.



## Avoid Timely Filing Denials

Quite often, claims are denied because they were not submitted within the required amount of time. A claim must be received by MedStar Select within 180 days from the date of service. Claims submitted after 180 days will be deemed as untimely and will not be paid.

There is an exception when coordination of benefits is involved. For example: If a member has both Medicare (primary carrier) and MedStar Select (secondary carrier), the filing must occur within 180 days from the date of the Medicare explanation of payment (EOP) to be considered timely. It is always required that the provider submit that EOP with the claim once they receive it. When a claim is submitted, please retain the EOP as your proof of timely filing. It is critical for providers to retain EOPs since this is the only acceptable proof that a claim has been filed in a timely manner.

Billing system printouts are not acceptable proof that a claim was filed in a timely manner. Providers should make every effort to submit claims as soon as possible. This allows providers additional time to submit corrected new claims within the required 180 day period.

For claims inquiries, including verifying receipt of a claim or inquiring about the status of a claim, call Provider Services at **855-222-1042** or log on to the provider portal at **MedStarProviderNetwork.org**. For provider online log in requests, call Provider Services at **855-222-1042** or email **provider\_support@togetherforyourhealth.com**.

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## Find it on the Web

The MedStar Select provider website at **MedStarProviderNetwork.org** includes resources such as:

- Provider Directory
- Provider Manual
- Medical Policies
- Payment Policies
- Pharmacy Formulary
- Benefits Booklet
- EDI Documents
- Reason Codes
- Quick Reference Guide [frequently updated]
- Medical Management Forms
- How to Become a Participating Provider
- Ancillary Provider Interest Form
- MedStar Newsletter
- Contact Us



## Excluded Parties - Payment Ban

According to the Federal guidance, Medicare payment may not be made for items or services furnished or prescribed by a provider or entity who has been excluded from participation in Federal programs. Providers should be aware of this provision and screen all employees and contractors for exclusion upon hire, then monthly thereafter. Payments may be retracted if reimbursement is directly or indirectly related to the excluded parties for items and services provided to a Medicare enrollee.

Prior to hiring an individual and monthly thereafter, providers should review the Department of Health and Human Services Office of the Inspector General (DHHS OIG) list of excluded individuals and entities (LEIE) and the General Services Administration (GSA) System for Award Management (SAM) to ensure that employees are not excluded from participation. The payment ban includes contractors, providers, employees, and suppliers. Searchable lists can be found on the OIG and GSA websites.

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## MedStar Select Site Evaluations

Site surveys are completed for all PCPs and specialists at the time of initial credentialing. If a member complaint is received about the physical condition of the provider office, a follow-up site audit will be performed.

New provider sites and site additions also require a site evaluation after Provider Relations is notified of the change or addition.

If you have any questions or comments regarding minimum standards for site evaluations, please contact your provider representative at **800-905-1722, option 5**.



# Providers Participating in MedStar Select

Please check **MedStarProviderNetwork.org** to confirm your office information is displaying correctly on the searchable online directory.

If there have been any changes or you become aware of an error, please contact Provider Relations at **MFC-ProviderDemographics@medstar.net**, **800-905-1722** to resolve. Help us to ensure that MedStar Select has the most accurate and up to date information!

## Claims Submissions

Claims must be submitted within 180 days of the date of service. Providers may submit a claim on paper, through a clearinghouse, or directly through the online provider portal.

- Paper claims should be mailed to:

MedStar Select Claims  
PO Box 1200, Pittsburgh, PA 15230-1200

- Electronic claims are accepted from clearinghouses, such as Emdeon, Relay Health, and Allscripts.

The payer ID for MedStar Select claims is 251 MS.

- Direct submission of claims for MedStar Select is available at **MedStarProviderNetwork.org**. Providers must sign up for a login to view eligibility, claims, and other patient specific information. If you have additional questions, please contact Provider Services at **855-222-1042**.

After claims are successfully submitted and received, payments are dispersed within accordance with all regulatory prompt pay guidelines. Please contact Provider Services to verify claims receipt, as well as claims status and inquiries, at **855-222-1042** or Provider Portal Support at **855-222-1043**.

Inquiries can also be made through the provider portal at **MedStarProviderNetwork.org**.



5233 King Ave., Suite 400  
Baltimore, MD 21237  
800-905-1722 **PHONE**  
**MedStarProviderNetwork.com**

The MedStar Select and MedStar Medicare Choice Newsletter is a publication of MedStar Health. Submit new items for the next issue to MedStar Family Choice Provider Relations at **mfc-providerrelations2@medstar.net**.

**Kenneth Samet**  
*MedStar Health President and CEO*

**Eric Wagner**  
*President, MedStar Family Choice*

**Margo Briscoe**  
*Manager, Provider Relations*

MedStar Franklin Square Medical Center  
MedStar Georgetown University Hospital  
MedStar Good Samaritan Hospital  
MedStar Harbor Hospital  
MedStar Montgomery Medical Center  
MedStar National Rehabilitation Network  
MedStar Southern Maryland Hospital Center  
MedStar St. Mary's Hospital  
MedStar Union Memorial Hospital  
MedStar Washington Hospital Center  
MedStar Ambulatory Services  
MedStar PromptCare  
MedStar Medical Group  
MedStar Visiting Nurse Association  
MedStar Family Choice  
MedStar Institute for Innovation  
MedStar Health Research Institute