Utilization Management-Authorization Review Process

Our experienced clinical staff reviews all requests. Pre-authorization decisions are based on nationally recognized criteria, such as Inter-Qual and Medicare guidelines. Additional authorization criteria utilized by MedStar Family Choice can be found at MedStarFamilyChoice.com under our utilization management (UM) process policy.

Decision making is based only on appropriateness of care and service and existence of coverage. We do not specifically reward practitioners or other individuals for issuing denials of coverage of care. In addition, there are no financial incentives for UM decision makers that would encourage decisions which result in underutilization. Providers may request a written copy of the criteria used during the decision-making process by contacting the Utilization Management department at 855-210-6203, Monday through Friday from 8 a.m. to 5:30 p.m. Authorization requests should be made no less than five to seven business days in advance of the service.

MedStar Family Choice has up to 14 days following the receipt of the request to process a complete authorization request. Requests are considered complete when all necessary clinical information is received from the provider.

An additional 14 days can be given to make a decision if it is requested by the member or the provider, or if MedStar Family Choice believes it is in the best interest of the member. For members with urgent authorization needs, the physician or a physician’s staff member should contact MedStar Family Choice Care Management at 855-210-6203. If MedStar Family Choice denies the pre-authorization request, the provider and member will receive a copy of the denial. In addition, the denial letter will indicate that the treating provider may contact the MedStar Family Choice physician advisor to discuss the case by calling 855-210-6203.
Report Fraud Abuse

MedStar Family Choice and MedStar Health have comprehensive compliance programs in place to monitor and detect fraud and abuse. Fraud and abuse could be committed by a provider, member or even an employee of the managed care organization. As a MedStar Family Choice provider, it is your responsibility to report fraud and abuse. Providers report fraud by calling the MedStar Family Choice compliance director at 855-210-6203, option 7 or the MedStar Integrity Hotline at 877-811-3411. You may also email: ocbi@medstar.net

A strict non-retaliation policy is in place for reporting suspected fraud and abuse. Some common examples of fraud and abuse are:

- Billing for a service that was never performed
- Unbundling of procedures
- Up-coding
- Performing unnecessary procedures
- Altering or forging a prescription
- Allowing others to use a member’s ID card for care

Most billing errors are oversights and not indicators of fraudulent activity. However, fraud and abuse does occur and MedStar Family Choice is responsible for monitoring, identifying and deterring these types of activities. As a result, we regularly monitor and audit claims submissions and encounter data. In addition, MedStar Family Choice performs routine and random chart audits as a part of the compliance program. Providers are subject to comply with these audits. If overpayments related to fraudulent or abusive billing have been identified, we may retract those payments made to providers. MedStar Family Choice may be required to notify the Department of Health Care Finance (DHCF) Office of Inspector General and Medicaid Fraud Control Unit (MFCU) of the retraction. DHCF or the MFCU may perform its own investigation. Penalties such as fines, loss of licensure or imprisonment can occur for providers found guilty of fraudulent activity.

Please note: When in the course of regular business, as part of an internal compliance program, or as a result of a self-audit a provider determines that payments made to the provider were in excess of the amount due from MedStar Family Choice, the provider is obligated to report and return the improper amounts.

Updated Quick Authorization Reference Guide

Thank you to all who have continued to provide comments to us about our Quick Authorization Reference Guide. We are pleased to have heard so many positive comments over the past year!

To address some of the questions we have received, MFC has made some updates to the Quick Authorization Reference Guide. Please review the revised MedStar Family Choice Quick Authorization Reference Guide carefully. Rules will be effective for all claims submitted on or after April 1, 2017.

For questions or comments related to this communication, please contact your MedStar Family Choice Provider Relations Representative in Maryland at 855-210-6203, option 5.
Acute Bronchitis

The treatment of acute bronchitis presents a challenge for most clinicians. While viral etiologies are suspected in 90 percent of cases, patients often expect an antibiotic to be prescribed. Weighing the evidence against patient expectations can be exceedingly difficult. The National Committee for Quality Assurance (NCQA) has set forth stringent goals through Healthcare Effectiveness Data and Information Set (HEDIS) regarding this issue. They are measuring the percentage of adults (ages 18 to 64) with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. The stated goal is avoidance of antibiotic treatment in adults with acute bronchitis. The purpose of this article is to lend support to practitioners in providing excellent evidence-based care while still maintaining patient satisfaction.

The most common viral infectious etiologies include adenovirus, coronavirus, influenza, metaneumovirus, parainfluenza, respiratory syncytial virus and rhinovirus. The most common bacterial etiologies are Bordetella pertussis, Chlamydia pneumonia and Mycoplasma pneumonia. Given that the vast majority of bronchitis cases are viral, it is reasonable to treat most symptomatically. However, there are certain instances in which antibiotics should be considered. If pertussis is suspected, a macrolide antibiotic will help lessen the risk of transmission (but will not lessen symptom duration). In addition, antibiotics should be considered in patients at high risk for pneumonia. Established risk factors for pneumonia include (but are not limited to) chronic lung disease, heart disease, immunosuppression, and age 65 or greater. Practitioners aim to provide the best, evidence-based care. Yet, it is not unreasonable to also aim for patient satisfaction. How might we allay patient apprehension about leaving the office without a plan for antibiotic therapy?

Suggestions include:

• Explain the diagnosis. Inform patients that in 90 percent of cases, this illness is caused by a virus. Go further and explain that antibiotics do not treat viral infections.

• Briefly detail the potential side effects of antibiotics. Severe diarrhea (C. difficile), nausea and serious allergic reactions are just a few that patients can easily comprehend.

• Anticipatory guidance is critical. Patients may believe that a “cold” should only last a few days. So, when the cough has persisted for a week, many think it is time to turn to antibiotics. Explain that the cough, congestion, rhinorrhea, etc. may last three weeks (sometimes longer).
• Offer symptomatic care. Patients may benefit from expectorants, mucolytics, antitussives, humidifiers at the bedside, etc. Use your best judgment with supportive measures, but keep in mind that the FDA issued a recommendation that children under the age of two not use cough and cold preparations due to the risk of serious side effects. Additionally, the American Academy of Pediatrics has stated that over-the-counter cough and cold medicines do not work for children younger than six years and in some cases may pose a health risk.

• Offer a script “to hold.” Patients often fear being trapped on a weekend without access to care other than ED or urgent care visits. Offering a script to fill at a later time if symptoms progress or worsen might lessen anxiety. It is definitely possible to provide excellent care while still maintaining a high level of patient satisfaction. Additional sources of excellent patient-centered information can be located at FamilyDoctor.org/Condition/Acute-Bronchitis or via the Centers for Disease Control website at CDC.gov/GetSmart/Community/For-Patients/Common-Illnesses/Bronchitis.html.

1. Albert RH. Diagnosis and Treatment of Acute Bronchitis. Am Fam Physician. 2010 Dec. 1;82 (11);1345-1350.

Contact Us

Each participating MedStar Family Choice provider is assigned a provider representative to assist offices with questions regarding Provider Contracts and the MedStar Family Choice health plan. Your representative is assigned to you according to the demographic area of your office. If you are not certain who your provider representative is, please call or email MedStar Family Choice Provider Relations, and we can assist you.

Provider Relations main telephone number: 855-210-6203, option 5 PHONE
855-600-3077 FAX
mfc-providerrelations2@medstar.net EMAIL

You may contact MedStar Family Choice at 855-210-6203, Monday through Friday, between 8:30 a.m. and 5 p.m. Providers have the option to leave a message or send a fax or email after normal business hours. However, any calls, faxes and emails received after hours will be addressed the next business day. Please call 855-210-6203:

Option 1 for Outreach and transportation
Option 2 for Pharmacy, pre-authorizations, inpatient reviews and case management or fax to 202-243-5495
Option 3 for Member Services or denials and appeals
Option 4 for Claims. Please listen for further options.
Option 6 for dental, vision, substance abuse or mental health
Option 7 for Compliance

For eligibility, PCP assignment and benefit information, please call 800-261-3371.
Cultural and linguistic differences can create barriers between providers and patients. These barriers may hinder healthcare professionals from understanding patient needs. Providers can positively enhance a patient-physician relationship by:

- Being focused on the patient during the visit
- Asking clear and concise questions
- Following up with additional questions to ensure the member understands the provider’s instructions

Quarterly updates will be available on this Website and more frequently on ePocrates. Paper booklets of the 2017 Formulary can be requested from the MedStar Family Choice Provider Relations department at 855-210-6203, option 5. Details of the prior authorization criteria are available on the MedStar Family Choice website with the other pharmacy protocols.

CHANGES BELOW WILL BECOME EFFECTIVE ON OR AROUND FEB. 15, 2017

Additions:
- Kyleena (levonorgestrel 19.5 mg) five year duration intrauterine device (IUD)
- Potassium iodide

Additions with prior authorization*:
- Rajani (drospirenone/ethinyl estradiol and levomefolate calcium) oral contraceptive
- Wymzya (norethindrone/ethinyl estradiol and ferrous fumarate) oral contraceptive

Please see the PA table on the MedStar Family Choice website for details of the requirements for approval and guidance on submission of clinical information.

Removals:
- None

Removal of prior authorization:
- None

Managed drug limitations and step therapy**:
- None

*Details of the prior authorization criteria are on the MedStar Family Choice website in the prior authorization table.

**Details of the step therapy criteria are on the MedStar Family Choice website in the Step Therapy Table.

Cultural Communication and Interpreter Services

Cultural and linguistic differences can create barriers between providers and patients. These barriers may hinder healthcare professionals from understanding patient needs. Providers can positively enhance a patient-physician relationship by:

- Being focused on the patient during the visit
- Asking clear and concise questions
- Following up with additional questions to ensure the member understands the provider’s instructions

For members that are hearing impaired or not proficient in English, MedStar Family Choice will provide telephonic interpretation services and/or professional on-site interpreters. Please contact our Care Management department at 855-210-6203, option 2, to schedule telephonic translation services or call Provider Relations at 855-210-6203, option 5, to coordinate an in-office interpreter. Please be aware that Provider Relations will need no less than five business days prior to a member’s appointment to coordinate an on-site interpreter.
Smoking Cessation Benefits

In an effort to assist our members who are interested in or are trying to live a smoke-free life, MedStar Family Choice offers a variety of smoking cessation classes and over-the-counter smoking cessation drugs that are free of charge to our members. Providers must write a script for over-the-counter medications and give it to the member to present to the pharmacy. A full list of covered smoking cessation products can be found on our formulary. If you have a patient that can benefit from a smoking cessation classes and/or a support group, you can find dates and times for these classes on our Health Education Schedule of Classes at [MedStarFamilyChoice.com](http://MedStarFamilyChoice.com). Additional counseling resources are also available for your patients through the Maryland Tobacco Quitline at [800-QUIT-NOW](tel:800-784-8669). Visit [Smoking Stops Here](http://SmokingStopsHere.com) for more information and materials. This program is available to all Maryland residents and provides confidential smoking cessation counseling 24 hours a day/seven days a week. Individuals 18 years and older interested in nicotine replacement therapy (NRT) may be eligible for free nicotine patches or gum. Specialized support programs are available for pregnant women and adolescents (13 to 17). If you are interested in how you can refer your patients directly to the Maryland Tobacco Quitline to help them quit smoking, consider becoming a Fax to Assist certified provider! Visit [MDQuit.org/Fax-to-Assist](http://MDQuit.org/Fax-to-Assist) or visit the MDQuit Resource Center web page at [MDQuit.org](http://MDQuit.org) for more information. Visit [MDQuit.org](http://MDQuit.org) or call the MDQuit Resource Center UMBC Psychology department at [410-455-3628](tel:410-455-3628) for more information on Maryland’s Quit Line.

**Did you know?**

When addressing tobacco dependence …

- Combining long-acting nicotine replacement treatment (NRT) options—like the patch—with short-acting NRT—such as the gum, lozenge or spray—can support quitting.

- Combination pharmacotherapy—using Varenicline and Bupropion SR together—appears to be more effective than use of either alone (Ebbert et al., 2009).

Visit [MDQuit.org/Cessation-Programs](http://MDQuit.org/Cessation-Programs).
Lead Testing Options

As a provider, it is important to follow the lead testing schedule as it applies to Medicaid recipients. As per federal and Maryland state law, it is the responsibility of healthcare providers to ensure that all applicable children receiving Medicaid get:

- A blood lead level performed at age 12 and 24 months
- A lead risk assessment survey completed at EVERY well-child visit from age six months to six years
- A blood level check for any patient with any item positive on a lead risk assessment survey

Children that have lead levels above five milligrams per deciliter are to be retested within three months. The child must be retested and the family should receive lead and nutritional education along with an assessment for other likely causes of lead exposure. In order to help providers meet these mandates, there are a few options for having the lead levels for MedStar Family Choice members tested. Providers may use LabCorp, MedTox and CLIA waived devices.

**LabCorp:**

Lead testing supplies can be ordered at no cost. These supplies are listed on the LabCorp requisition form. When a pediatric lead test is ordered, it requires a tan top tube. When an adult lead test is ordered, it requires a royal blue tube. Specimens are then sent to LabCorp for testing.

**MedTox:**

Primary care providers can use MedTox for MedStar Family Choice members. MedTox will provide filter paper lead supplies and pre-assembled comprehensive collection kits to providers at no charge. Postage paid and pre-addressed envelopes are included in the kits. Once the samples are placed in the pre-addressed envelopes and sent to MedTox, the results are reported back to the provider and the state within 72 hours. Account set up can be completed by faxing an account set-up form to Client Services at **651-633-1407** or by calling **888-834-8315**.

**Quest:**

Quest offers both blood and urine specimen testing for adults, and finger/heel sticks for testing children. Physicians must have a Quest account and can call for supplies or order online if the Care360 laboratory Ordering and Resulting Application is used. In-office testing requires lavender microtainers, lancets, tan-top vacutainer tubes and needles. No supplies are needed if a script is written that directs the patient/member to visit a PSC for specimen collection.

**CLIA waived devices:**

Primary care providers who purchased and are using CLIA waived devices in their office for blood lead testing can submit claims for CPT 83655 to MedStar Family Choice for processing. Reimbursement for CPT code 83655 is paid at the MedStar Family Choice fee schedule. Please contact MedStar Family Choice Provider Relations at **855-210-6203, option 5**, with questions and or inquiries.
Equal Access to Appointments

There are several federal laws that protect Medicaid recipients from discrimination. The national law that protects Medicaid recipients from being denied services because of race, color or national origin is Title VI of the Civil Rights Act of 1964. Title VI laws are enforced by the Office for Civil Rights (OCR). Other laws enforced by the OCR include the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act of 1990. As described within these laws, Medicaid recipients:

- Must not be discriminated against in the provision of healthcare services
- Are entitled to receive care without regard to race, color, creed, national origin, ancestry, age, sexual orientation, religion, gender, marital status, political beliefs, personal appearance, physical or mental disability or type of illness or condition
- Who arrive by their scheduled appointment time shall not wait more than 30 minutes from their scheduled appointment time to see a PCP

An example of discrimination includes offering fewer hours to Medicaid recipients than to commercial members and/or designating different office hours for Medicaid patients. Providers must provide the same access standards for all patients, regardless of the payer source. Services may not be denied or performed in a different manner, and members may not be subjected to segregation or separate treatment based on these factors. In accordance with Title VI of the Civil Rights Act, MedStar Family Choice provides translation services and performs site visits to confirm handicap accessibility. Providers must ensure that patients with impairments or who require an interpreter, are provided with these services as needed. Providers can contact MedStar Family Choice for assistance. Please report MedStar Family Choice equal access or discrimination concerns to our Provider Relations department at 855-210-6203, Option 5. More information regarding these laws can be found at HHS.gov/OCR, or you can call the U.S. Department of Health and Human Services Office for Civil Rights hotline at 800-368-1019.

Avoid Timely Filing Denials

A clean claim must be received by MedStar Family Choice within 180 days (six months) from the date of service. After 180 days, any claim submitted will be denied as untimely and the claim will not be paid. If the claim is first submitted to another insurance carrier (Commercial, Medicaid fee-for-service, etc.), claims must be submitted within 180 days (six months) from the date of the Explanation of Benefits (EOB) of the primary carrier. It is always required that the provider submit the EOB with the claim once they receive it. If a member has Medicare as a primary carrier, then the timely filing must occur within 18 months from the date of the Medicare EOB. When a claim is submitted, please retain the EOB as your proof of timely filing. It is critical for providers to retain their EOB since this is the only acceptable proof that a claim has been filed. MedStar Family Choice does not accept billing system print outs as proof that a claim was filed in a timely manner. Providers should make every effort to submit their claims as soon as possible. This allows providers additional time to submit corrected new claims within the six-month timeframe.
Second Opinions
On occasion, MedStar Family Choice members may request to seek a second medical opinion. Members have the right to do so and should be referred to a different in network provider by his/her primary care physician (PCP).

If an in-network provider is not available to provide a second opinion, an out-of-network provider can be requested. The member’s PCP should work with the patient, as well as the MedStar Family Choice Care Management department, when a second opinion must be scheduled with an out-of-network provider. A referral from the member’s PCP, along with a prior authorization from Care Management, prior to the member’s appointment with the non-participating physician, is required. Prior authorization can be obtained by faxing a Maryland Uniform Referral Form or the MedStar Family Choice prior authorization template to MedStar Family Choice Care Management at 410-933-2274 or by calling 855-210-6203, option 2.

Gynecological Services
Female MedStar Family Choice members may schedule all gynecological care, including Pap smears and annual and/or routine gynecological examinations, with either a primary care physician or a participating gynecologist without a referral. This includes all in-network primary care providers and gynecologists. Referrals and prior authorization are required for all out-of-network providers, including primary care and gynecologists.

If a member decides to utilize an in-network gynecologist for gynecologic services, please direct the member to a MedStar Family Choice gynecologist by utilizing our online directory, Find a Provider, at MedStarFamilyChoice.com or contact MedStar Family Choice Provider Relations at 855-210-6203, option 5, to request a listing of participating gynecologists.
Tips for Ensuring Patient Privacy

The HIPAA Privacy Rule and HIPAA Security Rule are federal laws that regulate what can and cannot be done with patient information. Protected health information (PHI) is “anything you see or hear that lets you know about the health of a specific patient.” Electronic protected health information (ePHI) is “any electronic form of PHI, including data stored on computer hard drives, file servers, data storage tapes, and CDs, as well as data transmitted electronically.” A few simple steps can help protect PHI and ePHI daily. These tips include:

• Do not leave patient information in areas where it can be viewed by unauthorized personnel.

• Sign-in sheets should not state the reason for the patient’s medical appointment.

• Face sheets should be turned toward the wall if patient charts are outside of an examination room.

• Keep confidential conversations at a low level.

• Leave minimum information regarding appointments on patients’ voicemails.

• Computers/workstations should be in an area that minimizes accidental/nonauthorized viewing of patient information.

• Assign strong passwords to computer systems.

• Do not share user IDs or passwords or post passwords in or around workstations where they can be viewed easily by others.

• Always log off of computers/workstations when leaving work for a long period of time or lock computers when away from the workstation.

• Add password-protected screensavers to personal workstations.

• Protect electronically transmitted PHI through encryption and password protect electronic patient information.

• Save PHI data to the appropriate locations and in the appropriate manner so the data is backed up regularly.

• Properly dispose of any documents or papers containing PHI in shredders or special destruction boxes. Visit the U.S. Department of Health and Human Services website at [HHS.gov](http://HHS.gov) for more information regarding HIPAA rules.

Did you know about the MedStar Family Choice Healthy Life Member Portal?

The MedStar Family Choice Healthy Life Portal is accessible by members 24/7, and features a health library with various health-related articles, videos, educational modules and a host of other great resources. Members can take various disease risk-assessments, enroll in e-learning and complete training that goes towards receiving incentives. Members can access the MedStar Family Choice Healthy Life Portal by going to [MedStarFamilyChoiceHealthyLife.com](http://MedStarFamilyChoiceHealthyLife.com).
Access and Availability Standards

MedStar Family Choice providers must offer hours of operation to MedStar Family Choice members that are no less in number or scope than the hours of operation offered to commercial or other Medicaid patients.

Regulations require providers to adhere to the following guidelines for appointment scheduling:

**Within 48 hours of discharge:**
- High-risk newborns

**Within 24 hours of request:**
- Urgent care appointments

**Within 30 days of request:**
- Initial appointment to new members 21 years and older
- Well-child appointments
- Routine and preventative primary care
- Routine specialist follow up
- Lab and X-ray within 10 days of request
- Initial assessment of pregnant and postpartum women
- Family planning service request
- Provider newsletter

**As a reminder, providers must also maintain:**
- 24-hour phone coverage; for example: An answering service and/or answering machine with directions for emergency care
- Office hours for MedStar Family Choice members that are equivalent to the office hours offered to commercial or other Medicaid patients
- Patient wait time that does not exceed 30 minutes after the scheduled appointment time to be seen for regular office visits
- Patients waiting longer than 30 minutes and emergency cases should be seen immediately.
- Throughout the year, MedStar Family Choice provider relations will monitor our provider network for adherence to these requirements.

** EPSDT HealthCheck (Providers)**

HealthCheck/primary care providers seeing patients under the age of 21 are required to complete the District’s HealthCheck Provider Training within 30 days of joining our provider network and every two years after the initial training. Providers who are not up to date on their training may not be re-credentialed with our health plan. This program is accessible online at [DCHealthCheck.net](http://DCHealthCheck.net) and requires a provider’s NPI to log-in. The training program is free for participating plan providers who are due to receive the training. Upon completion of the online training module, providers receive five free continuing medical education (CME) credits.
Perinatal Services

MedStar Family Choice offers a wide variety of prenatal and postnatal services to its members through our own programs, as well as those offered through affiliates and the District of Columbia. As a practitioner, you should feel comfortable recommending any of our programs to your applicable MedStar Family Choice patients. Some of our programs and services are listed below and, as always, members can contact MedStar Family Choice for additional information by calling 855-210-6203.

• Momma & Me Program: Members who are fewer than 28 weeks pregnant are eligible to participate in the Momma & Me program. Once enrolled in the program, the member can receive a $25 gift card for just going to all of her OB appointments and one dental checkup. Educational materials are also provided to the member when she enrolls in the program. Attending educational prenatal classes is also encouraged for the expectant mom to increase awareness of prenatal and postnatal health strategies.

• High-Risk Pregnancy Case Management: High-risk pregnancy case management identifies members who are at risk for pregnancy complications. A complete assessment is performed via telephone and evaluations are made regarding the mother’s current state of pregnancy. Issues discussed include compliance with medications, special diets, office visits and transportation to appointments. Educational needs reassessed and teaching is conducted on pregnancy related conditions, such as gestational diabetes and preeclampsia in addition to other health conditions.

• Postpartum Program (We Care): The We Care program offers a new mother an incentive in the form of a $25 gift card for receiving a postpartum exam and for taking her newborn to his or her first two-week, well-child visit.

• Transportation: MedStar Family Choice will provide free transportation to and from appointments for its members when seeing in-network providers. Members must call 866-208-7357 at least three days in advance to arrange transportation for routine visits or one day in advance for urgent visits.

• Baby Showers: MedStar Family Choice Baby Showers are conducted quarterly in the wards of D.C. with the highest rate of perinatal mortality statistics for members enrolled in the MedStar Family Choice Momma & Me program. Various community services present their programs to the member, such as WIC and the Safe Cribs program. An Ob/Gyn practitioner is also present to discuss the importance of prenatal care. Once a baby shower is scheduled, eligible members receive information via mailings and the member newsletter. Members can also contact MedStar Family Choice for additional information.