MedStar Family Choice

Third Quarter 2020

# Provider Newsletter

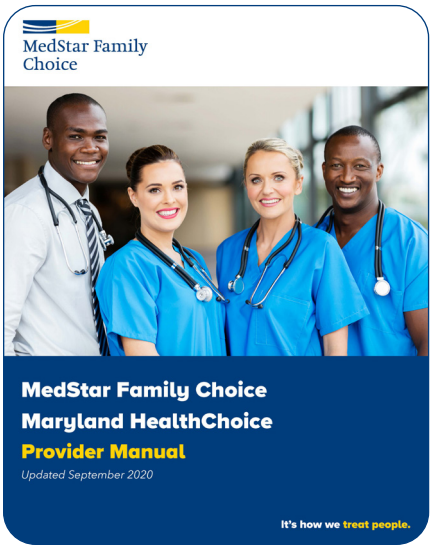
Maryland HealthChoice Program

## New Provider Manual Available Online

The MedStar Family Choice Provider Manual has been updated. While each HealthChoice Managed Care Organization (MCO) has its own policies and procedures, many program elements apply to all providers, regardless of the MCO. The purpose of the manual is to explain those elements and be a useful reference for providers who participate in the HealthChoice program.

The MedStar Family Choice Provider Manual advises you about the MedStar Family Choice MCO, including its policies and procedures relative to providing care. It also contains useful contact information to assist our network providers and their staff members.

The Provider Manual is now available for download on the MedStar Family Choice website or directly at **Bit.ly/MFC-ProviderManual**.




## Welcome New Providers to MedStar Family Choice

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

- **Charm City Eye Care** (Ophthalmology, Baltimore, Baltimore County)
- **Circles Healthcare LLC** (Family Medicine, Glenwood, Howard County)
- **Krishna Dass MD** (Infectious Diseases, Washington DC)
- **Lumiri Surgical LLC** (General Surgery, Bethesda, Montgomery County)
- **Podiatry Care Plus LLC** (Podiatry, Laurel, Prince George's County)
- **Privia Medical Group Kelly Collaborative Medicine** (Family Medicine, Silver Spring, Montgomery County)
- **Vision MD LLC** (Ophthalmology, College Park, Prince George's County)

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

- Ambulatory Surgical Center: **Clearway Surgery Center of Dundalk**
- Diabetes Prevention Program: **Canary Health, Continuum Wellness Center LLC, Taylored 4 Life Inc.**
- Radiology: **Calvert Medical Imaging Center**
- Skilled nursing facilities: **Chapel Hill Nursing Center**

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# Update to the MedStar Family Choice Formulary

Paper booklets of the 2019 formulary can be requested from the MedStar Family Choice Provider Relations department at **800-905-1722, option 5**. Details of the prior authorization criteria are available on the MedStar Family Choice website with the other pharmacy protocols.

**CHANGES BELOW ARE EFFECTIVE AS OF AUGUST 15, 2020.**


**Additions:**

- Signifor LAR (pasireotide)
- Tivicay PD (dolutegravir oral suspension)

**Additions with Prior Authorization*:**

- Darzalex Faspro (daratumumab and hyaluronidase-fihj, SQ admin)
- Pemazyre (pemigatinib)
- Retevmo (selpercatinib)
- Tabrecta (capmatinib)
- Oriahnn (elagolix, estradiol, and norethindrone acetate capsules)
- Trodelvy (sacituzumab govitecan-hziy)
- Tukysa (tucatinib)
- DexCom Continuous Glucose Monitoring System - Available through pharmacy benefit.
- FreeStyle Libre Continuous Monitoring System - Available through pharmacy benefit.

Please see the PA Table on the MFC 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 & 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.

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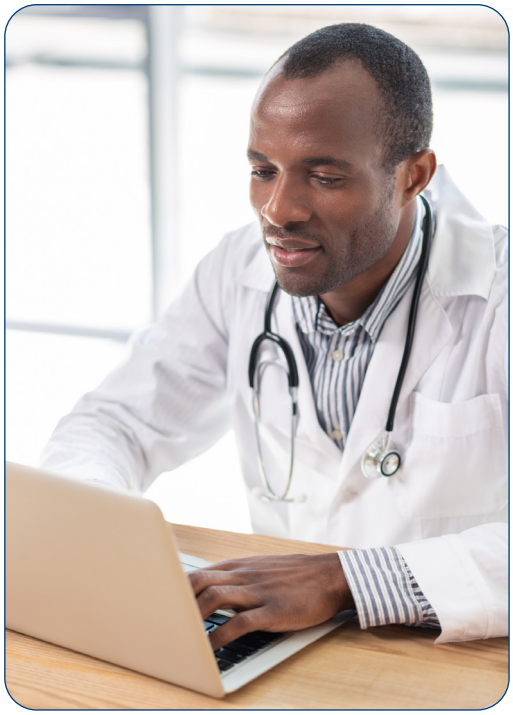
# Patient Safety Information Regarding Pharmaceuticals

We periodically receive safety information, including black box warnings or recalls, from our pharmacy benefit manager.

Visit **MedStarFamilyChoice.com** to view these safety updates, as well as current pharmacy protocols and clinical practice guidelines.

## Provider Credentialing and Recredentialing

Accurate and timely provider data is essential to keeping MedStar Family Choice's credentialing system running smoothly. MedStar Family Choice'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 Family Choice 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 Family Choice of the suspension, loss or reduction of hospital privileges.
- Providers must enroll with the state Medicaid agency, and maintain an active Fee-for-Service (FFS) provider number.

**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

## 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 nonparticipating 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 **800-905-1722, option 2**.

## Schedule Annual Physicals

**Annual Physical versus Sports Physical**

Throughout the year, physicals, immunizations, and blood tests are completed for daycare, schools and sports. MedStar Family Choice believes that it is very important that all children get appropriate and timely annual physicals. If you have a MedStar Family Choice member in need of a physical exam, prior to the anniversary date of their previous physical, MedStar Family Choice will cover the physical exam. We do not deny any claims for annual physicals if it is completed prior to the anniversary date of the last physical. This will ensure that our members are in compliance with the guidelines that are set by the Maryland Department of Health. Please note that a sports physical does not qualify as an annual physical.

Therefore, if a MedStar Family Choice member requires a sports physical, and they have not had an annual physical within the calendar year, providers are encouraged to complete an annual physical along with the sports physical. If you have any questions or comments, contact MedStar Family Choice Provider Relations at **800-905-1722, option 5**.

## Did you know we offer the "Momma & Me" Program?

Medstar Family Choice offers the Momma & Me program for eligible members who are expecting. By enrolling in the Momma & Me program, members will be eligible to receive gift cards for keeping their OB appointments. Member can earn extra gift cards by attending OB classes and seeing the dentist during their pregnancy. MedStar Family Choice members can also take online Momma & Me classes located on **MedStarFamilyChoiceHealthyLife.com**. Members or providers can call **410-933-3057** for more information.

## Components of a Postpartum Visit

Under the Medicaid program, members should have contact with their OB provider within three weeks of delivery and have a comprehensive postpartum care visit after. MedStar Family Choice looks to schedule that comprehensive visit or between 21 and 56 days after delivery. Members who receive a comprehensive postpartum exam within this timeframe may be eligible for a gift card. We will provide transportation to this specific postpartum appointment, if needed.

Members can contact our We Care postpartum coordinators, Jeanne Cox at **410-933-3062** or Lauren St. Pierre at **410-933-7255** to inquire about the program and schedule transportation. Please note: If a member receives a C-section, a suture check would satisfy the contact with the OB provider, but it must still be followed by a separate comprehensive postpartum visit.

## Coordinating an Organ Transplant

Getting ready for a transplant procedure takes a big commitment from the member and the member's family. As a result, we have nurses who become the member's MedStar Family Choice Case Manager. The Case Manager will assist to coordinate care with the transplant team as well as other providers. The nurse case manager begins the process by contacting the member to explain the program as well as completing a detailed medical and social history. They make sure the member knows what to expect and answers questions regarding provider appointments, provide education on what labs to expect, medication education, how long the process may take, discuss any addiction conditions and counseling on healthy food and lifestyle options. The nurse case manager stays involved with the member and the provider office through the entire process.

Providers are encouraged to contact Medstar Case Management Department a**t 410-933-2200**, option 2 to inquire if prior authorization is needed for pre-transplant specialty appointments/procedures. When the member is listed for an organ transplant, the referring physician is responsible for faxing all clinical documentation to MedStar Family Choice at **410-933-2205** or **410-933-2209**, in order to obtain authorization. This includes documentation of the facility where the transplant will take place, ICD-10® codes, listing letter, and documents supporting medical necessity. Both members and providers can contact our Organ Transplant Coordinators at **410-933-2200, option 2**.

## Pass-Through Billing

MedStar Family Choice 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 Family Choice.

"Per limitations provided in COMAR 10.09.02.04, providers may only bill Medicaid for services they or their employees have actually performed when billing for a service that includes both a technical and a professional component. Providers may not bill for services they have subcontracted to be performed by a third party. For example, a Dr. Smith enters into an agreement to pay ABC Consultants directly to interpret ultrasounds that Dr. Smith has performed. The agreement does not establish an employer employee relationship.

In this case, Dr. Smith would bill for the service using a modifier TC to indicate that he only performed the technical component of the service. Even though Dr. Smith has an arrangement where he has paid ABC Consultants to perform the professional component, Dr. Smith may not bill for the professional component because neither he nor his employees have performed the service. ABC Consultants would bill the Program for the professional component only using the modifier 26."

## PCP Auto Assignment

Members who fail to designate a primary care provider (PCP) after enrolling in MedStar Family Choice will be automatically assigned to a PCP that is geographically close to the member's residence. Members under the age of 21 are automatically assigned to EPSDT providers, as appropriate. Members may change PCPs at any time by calling Member Services. If your name is not listed on the member's card on the date of service, you are permitted to see the member as long as you are participating with MedStar Family Choice and the member is eligible with MedStar Family Choice on the date of service.

When possible, we ask that your office assist the member in having their member card changed to reflect the correct primary care provider by calling Member Services at **888-404-3549**.

Member rosters continue to be mailed to PCPs on a monthly basis, but this information changes daily and should not be used to determine member eligibility. Therefore, provider offices should be utilizing the state's EVS line to verify benefits on the date of service. Please contact our Outreach department at **800-905-1722, option 1**, if you have more questions regarding eligibility.

# Let's Decrease Emergency Room Utilization As A Team

MedStar Family Choice is looking to reduce emergency room (ER) utilization in 2019 for minor illnesses or injuries. As providers, you can have a meaningful impact on accomplishing this goal. When you see a MedStar Family Choice 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.
- Promote MedStar eVisit as it gives MedStar Family Choice members 24/7 video access to board-certified medical doctors at no cost. Members can connect with a medical doctor via secured video from their tablet, smart phone, or computer for non-urgent medical conditions. To learn more or schedule an eVisit, download the MedStar eVisit app or visit **MedStarHealth.org/eVisit**.
- Help us educate our members on the availability of their Nurse Advise Line benefit. Members can contact a nurse with questions or concerns about their minor illness or injury 24/7 by calling the nurse hotline at **855-210-6204**.

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

# Requirements Pertaining to False Claims and Statements

This is intended to provide you with information on laws pertaining to the prevention and detection of fraud, waste and abuse, in accordance with the requirements of the Federal Deficit Reduction Act of 2005. In addition, this article describes the procedures in place within MedStar Health and MedStar Family Choice for detecting and preventing fraud, waste and abuse. The MedStar Office of Corporate Business Integrity provides all MedStar Health facilities with compliance oversight, billing integrity support, occurrence reporting and resolution, and training and education. MedStar's Internal Audit department conducts routine, independent audits of business practices, and all financial managers are required to attend training on the financial manager's code of ethics and reporting obligations.

Employees, physicians, contractors, and patients are encouraged to report privacy, financial reporting, human resources, and other compliance concerns by making an anonymous and confidential call to the MedStar Integrity Hotline by calling **877-811-3411**, toll-free. The hotline is available 24 hours a day Employees, physicians, contractors, and patients can also email the compliance officer at ocbi@medstar.net. Any person reporting fraud and abuse may also contact the MedStar Family Choice Maryland Medicaid compliance director at **410-933-2283**. Retaliation for reporting in good faith, an actual or potential violation or problem, or for cooperating in a compliance legal or human resources investigation is expressly prohibited by MedStar policy. If overpayments related to fraudulent or abusive billing have been identified, we may retract these payments made to providers. In addition, under certain circumstances (Maryland Medicaid MCO Transmittal No. 82), MedStar Family Choice may be required to notify the Maryland Department of Health (MDH) OIG and Medicaid Fraud Unit (MCFU). These entities may perform their own investigation. Penalties such as fines, loss of licensure or imprisonment can occur for providers found guilty of fraudulent activity.

**Federal False Claims Act**

The Federal False Claims Act, 31 U.S.C. §§ 3729-3733, applies to persons or entities that knowingly and willfully submit, cause to be submitted or conspire to submit a false or fraudulent claim, or that use a false record or statement in support of a claim for payment to a federally funded program. The phrase "knowingly and willfully" means that the person or entity had actual knowledge of the falsity of the claim, or acted with deliberate ignorance or reckless disregard for the truth or falsity of the claim. Persons or entities that violate the Federal False Claims Act are subject to civil monetary penalties (42 U.S.C. § 1320a-7a) and payment of damages due to the federal government. Under the False Claims Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties. Each year the fines are adjusted for inflation. The Federal False Claims Act provides that any person with actual knowledge of false claims or statements submitted to the federal government may bring a False Claims Act action in the government's name against the person or entity that submitted the false claim. This is known as the False Claims Act's "qui tam" or whistleblower provision. Depending on the outcome of the case, a whistleblower may be entitled to a portion of the judgment or settlement. The Federal False Claims Act provides protection to whistleblowers that are retaliated against by an employer for investigating, filing or participating in a False Claims Act lawsuit.

**State False Claims Acts**

A number of states have enacted false claims acts in an attempt to prevent the filing of fraudulent claims to state funded programs. Maryland has a similar law, titled the Maryland False Health Claims Act of 2010, originally enacted as Maryland Senate Bill 279. The Maryland law prohibits actions constituting false claims against state health plans or programs, permits whistleblowers to bring actions under the law and provides protection for whistleblowers from retaliation. In Maryland, the civil penalty can be up to $10,000 for each violation. There can be an additional penalty of up to three times the amount of the damages that the state sustains. Depending on the outcome, the whistleblower may be entitled to a portion of the judgment or settlement.

## Effective Communications and CAHPS Audit Scores

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys are used as a tool to measure patient satisfaction and identify areas in need of improvement. For members, two of the CAHPS categories are "How Well Doctors Communicate" and "Getting Care Quickly."

Our 2020 adult population results, based on 2019 data, indicated an overall score of 91.81% for "How Well Doctors Communicate" a decrease from 95.88% in 2019. MedStar Family Choice facilitates communication with the member by providing materials written at a fifth-grade reading level as mandated by the state of Maryland. This, in combination with definitions and explanations, helps patients understand the messages being conveyed. As you are already aware, many patients have little experience with medical terminology and keeping it simple makes things easier for the patient to understand.

"Getting Care Quickly" reflected a score of 84.3% in 2020, a decrease from 85.11% in 2019. In conjunction with providing gaps in care data, MFC is constantly collaborating with the providers to address appointment barriers and assisting providers with scheduling members. If a member is having difficulties obtaining an appointment within the standard timeframe, we provide assistance with scheduling by calling the Outreach Department at **800-905-1722, option 1**.

Some cultural competency 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 and Human Services Think Cultural Health website at **ThinkCulturalHealth.HHS.gov**. For language barriers, providers should utilize interpretation services, as they are available through some patient insurance companies, such as MedStar Family Choice. Practitioners may contact our Provider Relations department at **800-905-1722, option 5**, to schedule in-office interpretation services for our members. Our members who contact physician offices with benefit questions should be directed to call our Member Services department at **888-404-3549**. They may also visit our website at **MedStarFamilyChoice.com**. Taking all of these steps will help to foster a good relationship between you and your patients.

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## Verifying Member Eligibility for Medicaid Products

Prior to rendering services, provider offices must verify that MedStar Family Choice Medicaid members have benefits on the date of service. If a member does not have benefits on the date of service, then claims will deny. Along with verifying member benefits, providers should be familiar with MedStar Family Choice products and that their office is contracted as a participating provider.

Providers should note which cards members are presenting and verify that they are contracted as a par provider. Sample member ID cards for each Medicaid product are available on our website at **MedStarFamilyChoice.com**. Please follow these steps to determine eligibility for your MedStar Family Choice–Maryland HealthChoice patients:

- Call the Maryland EVS line at **866-710-1447** to verify if a patient is eligible to receive benefits and is active with MedStar Family Choice on the date of service. More information on the EVS line can be found at **EMDHealthChoice.org**.
- If providers have further questions regarding member benefits under MedStar Family Choice, please contact the MedStar Family Choice Provider Services Call Center at **800-261-3371**.

***QUICK TIP**: To easily identify the correct MedStar Family Choice product, member ID numbers start with nine for Maryland HealthChoice.

# EPSDT Screening and Lab Reminder

The Maryland Healthy Kids/EPSDT program requires that specific screenings and required labs are completed for children enrolled in their program. The Maryland Healthy Kids/EPSDT program requires the following screenings and labs must be documented in the patient's chart:

- Anemia Screening: Screen at 12 and 24 months of age by performing a hematocrit (Hct) or hemoglobin (Hgb).
- Annual Anemia Risk Assessment, starting at age 11
- Annual depression screening with PHQ-9 or similar tools, starting at age 11
- Annual screening for Substance Abuse with validated tool (CRAFFT recommended), starting at age 11
- Annual STI Risk Assessment, starting at age 11
- Assessment of nutritional status includes documenting the typical diet by groups
  - "Normal diet," "all food groups" and similar documentation is not acceptable; Must actually list the food groups to be compliant
- Objective assessment for vision and hearing at more ages: 3, 8 and 10 years
- Two Dyslipidemia lab tests, one between 9 to11 years and the other between 18 to 21 years
- Recommended to receive three doses of HPV between 11 to 12 years, with catch-up period between 13 to 18
- Lead Risk Assessment and Blood Lead Testing: Use the Preventive Screen Questionnaire at each preventive healthcare visit from ages 6 months to 6 years old. Regardless of the results of the lead questionnaire, every child must have a blood lead level (BLL) test at 12 months and 24 months of age. Initiate BLL testing at any age and when documentation of a previous baseline BLL cannot be confirmed for children up to 6 years of age. The Maryland Department of Health (MDH), consistent with the new CDC guidelines, recommends that children with a lead level greater than the new reference level of five milligrams per deciliter should be retested within three months.
- Measurements and Graphing: Height and weight is required through 20 years of age and graphed on growth charts. Calculation and graphing of body mass index (BMI) and age gender BMI percentile is required on ages 2 to 20. Measurement and graphing of head circumference to age 2 is required. Blood pressure must be documented on ages 3 and older.
- Developmental Screening Tools, i.e. Ages and Stages Questionnaire (ASQ) or Parents Evaluation of Development Status (PEDS): These are purchased forms and cannot be photocopied. Implementation of the tools must be used at pediatric visits 9, 18 and 24 to 30 months. To obtain training on the tools, contact the Maryland Healthy Kids program at **410-767-1836**. Since there is an up-front cost to obtain these forms, the provider will receive reimbursement for utilizing the screening tools by billing CPT code 96110 on the HCFA 1500 form as each individual form is used.
- M-CHAT (Modified Checklist for Autism in Toddlers): This form is free of charge. It can be printed from the M-CHAT website at MCHATScreen.com and can be photocopied. The form should be used at pediatric visits at ages 18 months and 24 to 30 months. Providers are reimbursed for completing the M-CHAT.
- Substance Abuse Assessment: This assessment should begin at 12 years of age or younger, if indicated, with re-assessment yearly thereafter.
- Hearing and Vision Assessment: This assessment should occur during preventive care visits. Follow up with a qualified specialist for these elements may be indicated when a problem is identified. Newborn hearing screen follow up is required for abnormal results.
- STI/HIV Risk Assessment: Complete the risk assessment at each Healthy Kids visit beginning at age 12 or earlier according to the child's history. Follow up with appropriate assessments and testing when there is a "yes" answer to any of the questions on the Preventive Screen Questionnaire.

Please contact the Division of Healthy Kids program at **410-767-1836** with any questions.

Visit **MMCP.Health.Maryland.gov/EPSDT/Pages/Home.aspx** for more information.

## Chiropractic and Rehabilitation Services

Chiropractic services are not a covered benefit for adult members 21 years and older under Maryland Medical Assistance. As a result, chiropractic services, including physical therapy services provided by a chiropractor, are not a covered benefit for adult enrollees in MedStar Family Choice. Adult members referred for physical therapy must be referred to an in-network physical therapy provider who is contracted to provide physical therapy for MedStar Family Choice members.

Chiropractic services for members 20 years and under are covered. For a list of participating chiropractors, please visit the Find A Provider feature on **MedStarFamilyChoice.com**. When referring a member for chiropractic services, please note:

- Chiropractic referrals may only be written for the first 10 visits.
- Chiropractic visits (greater than 11) require prior authorization.
- Participating chiropractors are not contracted to perform physical therapy (PT) services for MedStar Family Choice, Maryland HealthChoice members.

While chiropractic services are not a benefit for our members 21 years and over, these members do have benefits for rehabilitative services, including medically necessary physical therapy, speech therapy and occupational therapy. When referring a member for PT/OT/ST services, please note:

- PT, OT and ST referrals may only be written for the first 30 visits.
- PT, OT and ST subsequent visits (greater than 30) require prior authorization. Referrals for members under the age of 21 are not the responsibility of MedStar Family Choice. Rehabilitative services for this age group are covered by the Maryland Medicaid fee-for-service program.

Providers may contact the Maryland Children's Health program for a list of participating providers at **800-456-8900**. As a reminder, please refer to our website for a listing of participating rehabilitation providers (PT/OT/ST). For questions, please contact Provider Relations at **800-905-1722, option 5**.

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## Excluded Parties Listing - Payment Ban

The Health and Human Services Office of the Inspector General (HHSOIG) publishes a list of providers that are excluded from receiving payments from the Medicaid program for any and all reimbursable items or services. The list was created to support and prevent fraud and abuse of the Medicaid program. The payment ban includes contractors, providers, employees of providers, etc. Providers should be aware of and screen all employees and contractors for exclusion since payments may be retracted if reimbursement is directly or indirectly related to the excluded parties for items and services received by a Medicaid recipient. A searchable list can be found on the List of Excluded Individuals and Entities (LEIE) on the HHSOIG website, as well as a separate look up for Maryland sanctioned providers and entities excluded from participation in the Medicaid program.

Visit **OIG.HHS.gov/Fraud/Exclusions.asp** for all lists. Both lists should be utilized and checked regularly. Questions and concerns regarding the LEIE can be directed to the chief compliance officer, Office of the Inspector General, at **410-767-5784**.

## Find a Provider Online

Finding a participating MedStar Family Choice provider couldn't be easier! Visit **MedStarFamilyChoice.com** to look up participating primary care physicians and specialists by logging on to our online provider directory. Providers can be found by:

- Physician/Group/Facility Name
- Service or Specialty
- Location
- Language
- Gender

Just complete one or more of the search fields and you will get updated information instantly. If your office does not have access to the web, please contact Provider Relations at **800-905-1722, option 5**.

## Did You Know?

We have nurses and social workers who are available to work with you to assist our members who require extensive use of resources or who need assistance to coordinate complex care. We also have a program to help members explore the option of gaining access to the state's Rare and Expensive Case Management (REM) program.

You can learn more about our case management programs by logging onto our website at **MedStarFamilyChoice.com** or by calling **800-905-1722, option 2**, and asking to speak with a case manager.

## Provider Performance Data

MedStar Family Choice may utilize 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 (using tiers) for narrow networks
- Reduced member cost sharing
- Other quality activities

Please contact Provider Relations at **800-905-1722, option 5**, with any questions and or concerns.

## You Can Find It on the Web

The MedStar Family Choice website is updated regularly. Users can log on to **MedStarFamilyChoice.com** and view:

- Appeal Process
- Availability of UM Criteria
- Case Management And Disease Management Services
- Change Requests or Demographic Updates
- Claims Information (including a link to the Online Claims Status Check)
- Clinical Practice Guidelines
- Contact Information for Medstar Family Choice
- Credentialing Process and Recredentialling Process
- False Claims Act/Fraud And Abuse
- Find-A-Provider (searchable provider directory)
- Formulary
- Hours of Operation and After-Hours Instructions
- Interpreter Services
- Medical Record Documentation Guidelines
- Member Rights and Responsibilities
- Notice of Privacy Practices
- Outreach Program
- Pharmacy Protocols and Procedures
- Pre-Authorization Requirements
- Provider Alerts
- Provider Manual
- Provider Newsletters
- Quality Improvement Programs
- Quick Reference Guide
- Schedule of Health Education Classes
- Transportation Guidelines
- Utilization Management Decision Making

If your office does not have access to the Internet, all of these materials are available in print by contacting our Provider Relations department, Monday through Friday, 8:30 a.m. to 5 p.m., at **800-905-1722, option 5**.

## Coordination of Care

MedStar Family Choice members often need follow-up care by the primary care provider after an inpatient admission when care was provided by specialists and when laboratory or diagnostic testing was performed. It is important that there is a process for ensuring that care is delivered seamlessly across a multitude of delivery sites by different providers. There should be mechanisms in place to ensure that members and clinicians have access to and take into consideration all required information on the member's conditions and treatments to ensure that the member receives appropriate healthcare services.

Therefore, it is important for the specialist to list on the referrals the name of the member's primary care physician (PCP). This is particularly important for OB/GYNs, who refer members for a Pap smear or mammogram. In most cases, the PCP is not aware that the member had a Pap smear or mammogram.

Specialists, PCPs, ambulatory facilities, and hospitals are to share reports and other documentation with each other in order to provide the quality of care our members need. At the same time, members are to assume responsibility by informing their PCPs and specialists of their current health status, as well as ensure that their doctors are aware of hospitalizations or recent tests that have been ordered. They need to inform the appropriate practitioner so that the results can be obtained.

The Quality, Outreach and Provider Relations departments at MedStar Family Choice will be working with the providers and members to try to improve this process. Please contact Provider Relations at **800-905-1722, option 5**, with suggestions, comments and questions.

## MedStar Family Choice 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 MedStar Family Choice chart audits, please contact Provider Relations at **800-905-1722, option 5**.

MedStar Family Choice

The MedStar Family Choice newsletter is a publication of MedStar Family Choice.

Submit new items for the next issue to MedStar Family Choice at **mfc-providerrelations2@medstar.net**.

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