First Quarter 2019

MedStar Health

MedStar Select Provider Newsletter

Provider OnLine

Provider OnLine is specifically designed for practitioners and providers affiliated with MedStar Select. The portal allows quick and efficient access to claims, benefit, and eligibility information for members, our associates and covered dependents. In addition, providers can chat online with Provider Services by clicking the link at the bottom of the home page.

In order to check eligibility and benefits, simply enter the member's identification number, last name, and first name, then click "Search." Eligibility results for applicable dependents and subscribers display within seconds. The result details show the member's specific benefits and effective date of benefits.

The Claim Inquiry search allows providers to search by member, associate, covered dependent or claim information online to obtain real time claims status. Detailed CMS-1500 and UB claim detail is supplied, including adjustment reasons, by clicking on the applicable claim from the search results. Providers who have questions on claims can compose an email to Provider Services on the claim detail screen directly.

You can also save time by messaging or chatting directly with Provider Services through the Provider OnLine portal. Communications are sent directly to the appropriate service area by selecting the applicable topic.

Provider OnLine also offers the capability to accept prior authorizations submitted by providers electronically. Once submitted, providers are able to view the status of their request as well as make edits up until a decision has been rendered. If you are interested in obtaining access to submit requests electronically, please notify **mfc-providerrelations2@medstar.net** to request permission. Requests will continue to be accepted via phone and fax as well.

If you are not already registered for Provider OnLine, sign up through **http://Secure.TogetherForYourHealth.com/WebRequests/Requests/SecurityRequest.aspx**.

For further information on the Provider OnLine portal, please contact Provider Services at **855-242-1042**.

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**.

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

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:

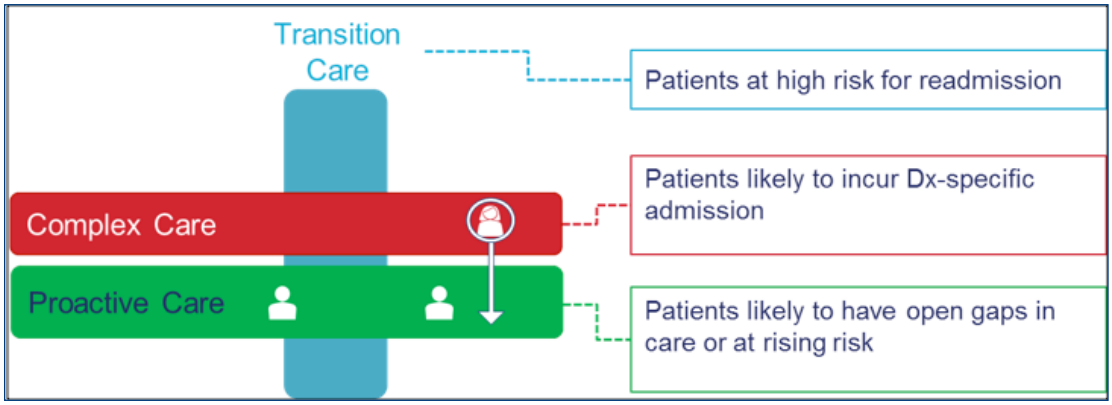
- Transition care, which focuses on patients who are at high risk for hospital readmissions
- Complex care, which focuses on patients likely to incur a disease-specific admission
- Proactive care, which focuses on patients who are likely to have open gaps in care or are at rising risk

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.



Credentialing and Recredentialing

Credentialing

MedStar Family Choice uses the Council for Affordable Quality Healthcare (CAQH) ProView database to streamline credentialing, reduce the amount of time and resources needed for credentialing, and to help improve provider data accuracy.

New providers joining and existing group that's currently participating/contracted with MedStar Family Choice should complete and submit the MedStar Family Choice CAQH Medical Data Sheet along with a copy of their Disclosure of Ownership and Control Interest Statement. Providers who do not use CAQH ProView may complete and submit the appropriate state credentialing application:

- Maryland - Maryland Uniform Credentialing Form (MUCF)

If you or your group is currently not participating/contracted with MedStar Family Choice, please contact Provider Relations at **800-905-1722, option 5** for contracting and credentialing questions.

Credentialing Requirements:

- A complete CAQH or MUCF application and agreement
- Active privileges in good standing at a MedStar Family Choice participating hospital
- A current, valid, and unrestricted state license to practice
- A current, valid, unrestricted DEA or CDS certificate, if applicable
- Board certified (Specialists only), or must be Board Eligible/Qualified
- Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates
- Professional liability insurance coverage ($1M per claim/$3M per aggregate)
- Work history for most recent five years (employment gap that exceeds six months must be explained)

Recredentialing

MedStar Family Choice has established a three year recredentialing cycle in order to comply with state/federal regulation and the National Committee for Quality Assurance (NCQA), which is an accrediting body. Provider recredentialing is now easier thanks to the Council for Affordable Quality Healthcare (CAQH), which gives MedStar Family Choice direct access to provider applications thereby reducing the time and resources needed to complete recredentialing.

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To complete the recredentialing process, we will obtain provider applications and supporting documents from the CAQH database. To avoid delays during this process, providers should:

- Maintain a current CAQH ProView profile.
- Re-attest to their CAQH data every 120 days.
- Upload current supporting documents directly into CAQH ProView (e.g., current malpractice insurance certificate, board certification certificate, etc.) to eliminate the need for manual submission, and to improve the timeliness of completed applications.

Providers who do not have a CAQH ProView profile will receive a recredentialing notification letter approximately six months prior to their recredentialing date, and the letter will include instructions for submitting the recredentialing application and supporting documents.

Providers may be terminated from the MedStar Family Choice network for failure to submit and/or update materials (CAQH or state application, current attestation, professional malpractice insurance certificate, etc.) for recredentialing within the required timeframe.

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.

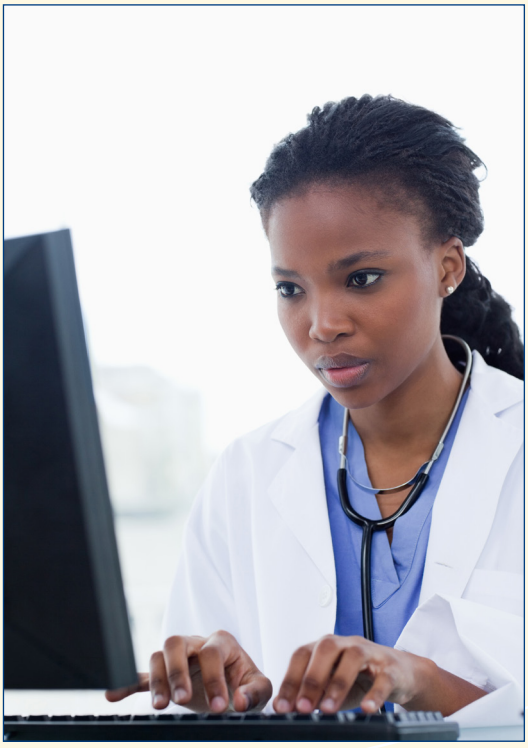
- Paper claims should be mailed to:

  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**.

MedStar Select Pharmacy Benefits

MedStar Select members are covered under a prescription benefit plan administered by Evolent and 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
- Diptheria
- Zoster (Zostavax®)
- Tetanus
- Diptheria Toxoids
- Pertussis
- Hepatitis A
- Hepatitis B
- Haemophilus B
- Human Papillomavirus (Gardasil®)
- Meningiococcal
- Varicella
- Inactivated Poliovirus
- Measles
- Mumps
- Rubella
- Rotavirus
- Meningococcal
- Varicella

Member Complaint/Grievance and Appeal Process

The MedStar Select complaint/grievance and appeal procedures can follow can be found on our website at **MedStarProviderNetwork.org** and in your provider manual. You may also call our Provider Relations department at **800-905-1722, option 5**, for a copy of the manual. The process will explain the following:

- How members can file a complaint, grievance, or appeal, and the differences between them
- How quickly we will respond to the member and the provider
- What to do if the member does not agree with our decision

Providers may not appeal a decision on the member's behalf without written permission from the member.

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**.

Tips for Ensuring Patient Privacy

HIPAA/HITECH rules are federal laws that regulate what can and cannot be done with patient information. Personal health information (PHI), also referred to as protected health information, generally refers to demographic information, medical history, test and laboratory results, insurance information, and other data that a healthcare professional collects to identify an individual and determine appropriate care.

PHI is any information about health status, provision of health care, or payment for health care that is created or collected and can be linked to a specific individual. 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, emails or text messages.
- Computers and workstations should be in an area that minimizes accidental and 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 and workstations when leaving work for a long period of time or lock computers when away from the workstation.
- Add password-protected 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.

You can visit the U.S. Department of Health and Human Services' website at **HHS.gov** for more information regarding HIPAA rules.

Denials and Disputes

All denied claims are reported on the explanation of payment (EOP), referred to on the statement as a remittance advice. This indicates whether the provider has the right to bill the member for the denied services and/or if the member is financially responsible for payment.

If a provider disagrees with the MedStar Select plan's decision to deny payment of services, the provider must file a dispute in writing to the appeals coordinator within 120 (administrative) or 180 (medical necessity) days of receipt of the denial notification. The request must include the reason for the dispute and any relevant documentation, which may include the member's medical record. Provider disputes should be submitted to:

MedStar Provider Appeals
PO Box 269
Pittsburgh, PA 15230-0269

All provider disputes undergo an internal review process, which meets all applicable regulatory agency requirements. The provider will receive written notification in all situations in which the decision to deny payment is upheld. Corrections or resubmissions of claims due to minor errors or omissions should be sent to the customary claims address.

Administrative Disputes

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

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

Administrative disputes must be submitted in writing within 120 days from the date of the notice. All decisions are final.

Medical Necessity Disputes

A dispute related to medical necessity disputes must be submitted in writing within 180 days from the date of the notice of denial. The Medical necessity dispute request should include the reason for the appeal, a clear statement of why and on what basis the provider wishes to appeal, as well as a copy of the medical record or other supporting documentation. A physician will determine if additional information has been presented that supports a reversal of the denial.

If you have questions about the right to file a dispute or the procedure to file a dispute, or wish to request a hard copy of this information, please contact your Network Management representative or call Provider Services at **855-222-1042**.

Tips and Additional Discussions to Improve Your Patients' Medication Adherence Rates

Each visit with your patient should consist of a comprehensive review of medications. Be sure to discuss any concerns your patients may have so you can better assist them with cost, side effects or other health improvement tactics.

If your patients are having trouble adhering to their medications, consider the following reasons:

- Cost
- Access
- Side effects
- Forgetfulness

As their provider, you may be able to help by considering the following:

- Why they have chosen to stop taking their medications?
- Are there alternatives available to cut down costs and/or minimize side effects?
- Have they been provided with medication-related education?
- Do they have access to a pharmacy that delivers?
- Are they using a pillbox to organize their medications?
- Have they been encouraged to relate pill-taking to daily activity?
- Are they interested in enrolling in an auto-refill program offered by mail order or a local pharmacy?

If your patients have questions in between visits, encourage them to contact your office.

Providers Participating in MedStar Select Plan

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-providerrelations2@medstar.net** or **800-905-1722, option 5** to resolve.

Help us to ensure that MedStar Select has the most accurate and up to date information!

MedStar Select Helpful Hints

Below are quick references and helpful reminders for your practice. If you have additional questions or concerns, please contact Provider Services at **855-242-1042**.

- A listing of services requiring requiring medical prior authorization is listed on **MedStarProviderNetwork.org**. In addition, the prior authorization process and forms can be found in the medical policies folder on **MedStarProviderNetwork.org**. For pharmacy prior authorizations, you can also refer to the pharmacy section in the provider manual, which also describes the process for prior authorizations for specialty pharmacy and drugs covered under the medical benefit.
- Provider Referrals
  - MedStar Select members do have out of network benefits at a higher cost share. For the lowest out of pocket cost, please refer members to MedStar Select providers located in the provider directory.
  - If you have questions, prior to referring providers, please contact Provider Services at **855-242-1042**.
- Claim adjudication from the date of provider transmission could take up to 30 days. Providers can inquire on the provider portal at **MedStarProviderNetwork.org** for the status of a claim.

Find a Provider in our 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 visiting 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 Relations at **800-905-1722, option 5**.

Medical Policies

Participating providers should review the medical policies requiring prior authorization and the medical payment policies posted on our website, **MedStarProviderNetwork.org**, for updates.

All medical policies are PDFs and can be downloaded. To request hard copies of materials, please contact Provider Relations at **800-905-1722, option 5**.

Reporting Fraud, Waste, and Abuse to the Health Plan

It is your responsibility to report known or suspected noncompliance pertaining to fraud, waste, or abuse. Some common examples of fraud and abuse include:

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

Many billing errors are oversights and are not indicators of fraudulent activity. However, fraud, waste, and abuse does occur. There are numerous ways to report a known or suspected fraud, waste, or abuse issue, including but not limited to the methods noted below.

MedStar Health Inc. has an established hotline for reporting known or suspected noncompliance including concerns pertaining to fraud, waste, or abuse committed by an entity providing services to a member. The MedStar Integrity Hotline at **1-877-811-3411** allows for anonymous reporting if you wish to report anonymously.

A known or suspected concern may be reported by calling the Integrity Hotline at **1-877-811-3411**. You may alternatively email a report to the Integrity Hotline at **https://www.compliance-helpline.com/medstar.jsp**.

You may report noncompliance by contacting MedStar Select's Diversified Compliance Officer, Kacper Szczepaniak, at **410-772-6739**. You may alternatively mail your fraud, waste, or abuse concern to MedStar's Office of Corporate Business Integrity. If reporting by mail, please mark the outside of the envelope "confidential" or "personal" and mail to:

MedStar Health Inc.
Office of Corporate Business Integrity
10980 Grantchester Way 6th Floor
Columbia, MD 21044
Attn: MedStar Select Diversified Compliance Officer

MedStar's website contains additional information on reporting noncompliance. If overpayments related to fraudulent or abusive billing have been identified, the health plan reserves the right to retract those payments made to providers.

MedStar Health

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

The MedStar Select and MedStar Medicare Choice provider newsletter is a publication of MedStar Health.

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

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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 Family Choice
MedStar Medical Group
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